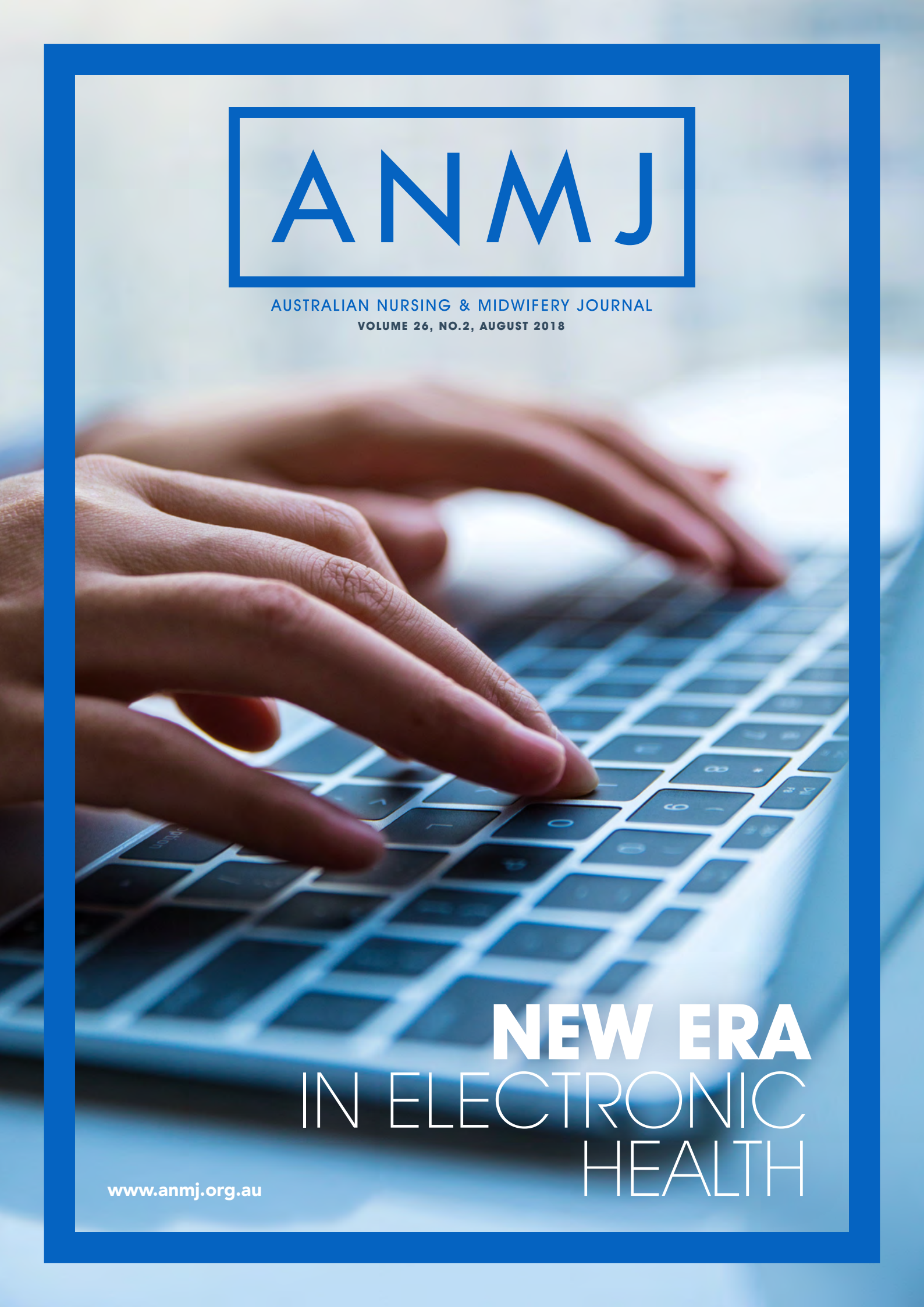




ANMJ

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MINIMUM PRODUCT INFORMATION: TRUMENBA[®] Meningococcal group B vaccine Suspension for IM Injection. **Indications:** Active immunisation in individuals 10 years and older to prevent invasive meningococcal disease caused by *Neisseria meningitidis* serogroup B. **Contraindications:** Hypersensitivity to the active substances or excipients. Severe allergic reaction after any previous dose of Trumenba or to any vaccine component. **Precautions:** Safety and efficacy in children below the age of 10 years of age has not been established. Ensure appropriate medical treatment and supervision is available in case of a rare anaphylactic event following vaccine administration. Do not inject intravenously, intradermally, or subcutaneously. Syncope can occur following/before any vaccination; Caution required in thrombocytopenia, coagulation disorders or individuals on anticoagulant therapy, unless the potential benefit clearly outweighs the risk of administration. Immunocompromised individuals, including those on immunosuppressant therapy, may have a diminished immune response. Trumenba may not protect all vaccine recipients. Not studied in adults older than 65 years of age. Only use during pregnancy (Category B1) and/or breast-feeding if clearly needed and advantages outweigh the potential risks. **Interactions With Other Medicines:** Can be given concomitantly with several other vaccines at separate injection sites and using separate syringes. Do not mix Trumenba with other vaccines/products. **Adverse Effects (Very Common/Common):** injection site pain, redness and swelling at the vaccination site, headache, fatigue, chills, diarrhoea, muscle pain, joint pain, nausea, vomiting, fever. Allergic reactions and syncope observed post-marketing. **Dosage and Administration:** For intramuscular use only. Schedule for routine immunisation: 2 doses (0.5 ml each) administered at 0 and 6 months. Schedule for individuals at increased risk of invasive meningococcal disease: 2 doses (0.5 ml each) administered at least 1 month apart, followed by a third dose at least 4 months after the second dose. Trumenba is not interchangeable with other meningococcal group B vaccines due to different vaccine compositions, age indications and dosing schedules. Before prescribing, please review Product Information available from Pfizer Australia Pty Ltd. [®]Registered trademark V11117. Pfizer Australia Pty Ltd, Sydney, Australia. PP-TRU-AUS-0033. Date prepared: June 18.

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- TRUMENBA is contraindicated in those who have hypersensitivity to the active substances or any excipients in the vaccine
- Administered by intramuscular injection only
- TRUMENBA is not interchangeable with other MenB vaccines

Did you know?

In Australia, serogroup B caused more than 50% of notified IMD in 15 – 19 year olds in 2017.²

References: 1. TRUMENBA Approved Product Information. 2. Invasive Meningococcal Disease National Surveillance Report - With a focus on MenW - 31 December 2017. Australian Government Department of Health. Accessed online (June 2018): <https://goo.gl/eeuNb5>. 3. Pfizer data on file. 4. Marshall H, *et al.* Lancet Infect Dis. 2017;17(1):58-67. 5. NCIRS. Meningococcal Disease. Fact Sheet. February 2018. Accessed online (June 2018): <https://goo.gl/HGJR41>. 6. Zlotnick GW, *et al.* Hum Vaccin Immunother. 2015;11(1):5-13. 7. TRUMENBA US Prescribing Information.

Abbreviations: dTap-IPV, combined low-dose diphtheria, tetanus, acellular pertussis and inactivated poliomyelitis virus vaccine; HPV4, quadrivalent human papillomavirus vaccine; IMD, invasive meningococcal disease; MenACWY, meningococcal serogroups A,C,W,Y conjugate vaccine; MenB, meningococcal B; Tdap, tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis vaccine.



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If you are a financial member of the ANMF, QNNU or NSWNMA, you can transfer your membership by phoning your union branch. Don't take risks with your ANMF membership – transfer to the appropriate branch for total union cover. It is important for members to consider that nurses who do not transfer their membership are probably not covered by professional indemnity insurance.



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Editorial

Annie Butler ANMF Federal Secretary

It has been a busy couple of months attending ANMF State Branch annual delegate conferences around the country.

The conferences are a great opportunity for ANMF Assistant Federal Secretary Lori-Anne Sharp and me to meet or reconnect with many of you in every state and territory. They are also an occasion for nurses and midwives to network with each other to discuss issues most important to them.

A substantial proportion of the conferences are dedicated to discussing and debating resolutions on industrial, professional, political and social justice issues, which are put forward by ANMF members. If those resolutions are passed they help shape policy and direction for each of the branches.

Speaking at the conferences has also been an opportunity to highlight the ANMF's aims to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems.

I AM DELIGHTED TO ANNOUNCE THAT THE MUCH ANTICIPATED ANMJ WEBSITE AND FACEBOOK PAGES ARE NOW LIVE.

Our key priorities are:

- work to equip the nursing and midwifery professions to deliver safe and quality care;
- to promote the professional and personal safety and wellbeing of nurses, midwives and carers;
- to position nursing and midwifery as expert advocates on health and social issues;
- to develop evidence to inform and influence national health and aged care policy; and
- to contribute to ensuring an economically and environmentally sustainable future for all communities.

Additionally I have been talking about the ANMF's campaign to make Australian aged care better through fixing the staffing crisis by making ratios law. We need safe staffing laws that guarantee aged care providers use taxpayers' money to provide better care for the elderly by employing enough staff instead of making increased profits.

These aims, priorities and the campaign itself have been met with much enthusiasm and support. It is because of this passion I am assured that our nursing and midwifery professions are in good hands and will continue to grow and evolve in the years to come.

Last month we said farewell to retiring ANMF Federal Senior Industrial Officer Nick Blake who has worked with the federal industrial team for over 22 years. Nick has contributed significantly to improving industrial conditions for nurses and midwives over the years. A touching account of his achievements written by the federal industrial team is in this month's ANMJ.

We welcomed James Lloyd as new Federal Vice President to the ANMF federal leadership team. James also holds the position of ANMF Tasmanian Branch President. ANMF Assistant Federal Secretary Lori-Anne Sharp, ANMF Federal President Sally-Anne Jones and I look forward to working with James in the months ahead.

As I sign off I am delighted to announce that the much anticipated ANMJ website and facebook pages are now live. The sites are jam packed with the latest news, interesting articles and helpful tips and hints relevant to all nurses and midwives. I encourage you to visit these sites regularly to keep informed on the latest information.

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Annie



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JAMES LLOYD: A PASSION FOR ADVOCACY



James Lloyd has been appointed new Federal Vice President of the ANMF. In speaking to Mr Lloyd he says he is passionate about giving a voice to the voiceless.

Mr Lloyd likes to represent people in resolving workplace issues. "I also try to encourage them to stand up for themselves. Having a voice and being heard is both powerful and satisfying."

Also in the position of ANMF Tasmanian Branch President, Mr Lloyd is a registered nurse with 25 years' experience.

He says nurses have a right to be heard. "We have a right to have a voice, to say something when we need to and not be afraid. People with authority and power only have that power if we let them wield it."

Most of Mr Lloyd's career has been spent working at the Royal Hobart Hospital (RHH) in Tasmania. After graduating in 1993, Mr Lloyd spent seven years as a neuroscience nurse, before training to become an intensive care nurse. After eight years in intensive care, he embarked on a new career direction as an After Hours Nurse Unit Manager at the RHH.

"From a local Branch Council point of view this has been beneficial. I bring an understanding of what's happening in my hospital, in the healthcare system in Tasmania, of the problems we face and of what does or doesn't tick."

Mr Lloyd says one of the issues is that governments are trying to squeeze extra efficiencies without looking at how services are best delivered.

"We have to justify every dollar and everything we do as a business case."

Staff get exhausted, they get disillusioned, and they move off to find areas with less stress, says Mr Lloyd. "There is skills dilution - workplaces lose the experience and skills of senior staff. It's about valuing people in the workforce and the skills they have and bring to the workplace."

Some aspects of healthcare are worse than they were 25 years ago, argues Mr Lloyd.

"Aged care has become a profit driven business. One of my colleagues was relating a recent example of where one of the nursing

homes had changed operators. They [new operators] immediately started cost reducing measures, which included halving the food portions for residents. Those are profit making decisions."

In 2011, Mr Lloyd was elected to ANMF Tasmanian Branch Council. He has been a member of Branch Executive, elected Vice President and is currently President. Mr Lloyd has been actively involved in public enterprise bargaining, media, as well as more broadly representing the ANMF at the RHH.

"One of the things with being on Branch Council is that it has really identified my passion for unionism and my passion for advocacy. I am passionate about standing up for the little person. I have learnt a lot about governance in the union movement. It's also provided me with contact with people in the wider health sphere and allowed me to have an influence."

The union is an advocate for the patient as well as its members, says Mr Lloyd.

"On Council we make decisions based on what members want but ultimately what is good for the patient. Nurse to patient ratios look like a good deal for nurses but it's a good deal for patients."

The extent to which service provision and access to healthcare is cost-driven drives Mr Lloyd to advocate for the protection of our universal healthcare system. "When we start stepping in the direction of an American model of healthcare it's the people who can least afford healthcare who suffer the most. Nursing comes with a philosophy of universal care: we care for people no matter who, what, where or why, we do not bring management or politics into it."

AGED CARE HOMES FACE UNANNOUNCED AUDITS

Unannounced audits have started rolling out across Australia's almost 2,700 residential aged care homes.

Billed as a new era of aged care quality and safety compliance by the federal government, nursing homes will no longer receive notices prior to their re-accreditation audits.

Aged Care Minister Ken Wyatt said audit teams could arrive at any time to monitor and ensure the provision of safe and quality care and declared the move a major shift towards customer-directed care.

"This is about certainty and confidence for older Australians and their families whose loved ones are receiving care," Mr Wyatt said.

"Statistics show that, overwhelmingly,

Australia's aged care homes provide outstanding services but our focus must be on maintaining high standards across the board at all times."

The tougher audits follow recent federal Budget funding of \$32 million for an independent Aged Care Quality and Safety Commission, due to begin in January next year.

The Commission will aim to improve compliance, strengthen the risk profiling of aged care providers and develop a Serious Incident Response Scheme, effectively combining the functions of the current Australian Aged Care Quality Agency, the Aged Care Complaints Commissioner and the Department of Health.

The new re-accreditation audit scheme, prompted by key recommendations of the Review of National Aged Care Quality Regulatory Processes, builds on the existing system of unannounced visits by the Aged Care Quality Agency.

"Since last July, the Agency has conducted almost 3,000 unannounced assessment visits on homes, targeting specific quality standard requirements, with nine homes losing their accreditation," Mr Wyatt said.

To continue receiving federal funding, aged care homes must comply with four standards comprising of 44 required outcomes, including clinical care, nutrition, hygiene, dignity, privacy and security.

Aged care residents are also encouraged to provide feedback, with audit teams required to meet with at least 10% of the home's residents to conduct Consumer Experience Interviews, with the results later published on the Aged Care Quality Agency's website.

The ANMF is currently running a national campaign calling on federal politicians to legislate aged care staff ratios in order to ensure vulnerable elderly residents receive proper care.

Speaking at an Aged Care Workforce Forum in Melbourne recently, ANMF Federal Secretary Annie Butler challenged aged care providers to respect and recognise the meaningful work carried out by aged care workers.

"Workplace environments are stressful. Workers feel unsupported and way too often governments and employers deflect and seek to blame workers for the problems occurring in the sector rather than addressing these challenges," Ms Butler said.

NEW ANMF FEDERAL LEADERSHIP TEAM AT THE HELM



L-R ANMF ASSISTANT FEDERAL SECRETARY LORI-ANNE SHARP AND ANMF FEDERAL SECRETARY ANNIE BUTLER

The Australian Nursing & Midwifery Federation has sworn in a new federal leadership team to lead the union in 2018 and beyond.

The Federal Executive positions were appointed at an extraordinary meeting of the ANMF's Federal Executive in June.

Annie Butler was formally appointed as ANMF Federal Secretary, having served as the Assistant Federal Secretary since March 2014.

Ms Butler is a registered nurse with more than a decade's experience working in public hospitals, the community and on health education projects, and a further decade working in research and education.

She worked for the New South Wales Nurses and Midwives' Association, for a further decade, as a professional officer, organiser and lead organiser, prior to moving to the national position of Assistant Federal Secretary.

Ms Butler says we must fight to maintain the professions of nursing and midwifery in Australia and to ensure their advancement.

"I am passionate about improving Australia's system of health and aged care and the critical role nurses and midwives have to play in the future of our health system."

Ms Butler is particularly keen to see nurses drive change for improvements in Australia's aged care sector.

Lori-Anne Sharp has been appointed ANMF Assistant Federal Secretary. She has been nursing for over 22 years.

The majority of her career has been in district nursing working for the Royal District Nursing Service (RDNS). A decade ago she took up a role with the RDNS Homeless Persons Program (HPP) and managed a team of nurses who delivered healthcare to some of the most vulnerable.

Ms Sharp started as a Job Representative in 2001 before joining the Victorian Branch Council in 2004 through to 2018. She has held positions on Branch Executive, including Branch Vice President.

Ms Sharp is committed to the nursing profession and mobilising the nursing workforce.

"I look forward to continuing the important work of the Federation by building on our collective strengths as Australia's largest union. Nurses, midwives and carers who represent over 70% of the healthcare workforce deserve to be valued, respected and heard."

Sally-Anne Jones has been ANMF President since April 2015. Ms Jones began nursing as an AIN in aged care, and has a background in oncology and emergency nursing having held a variety of roles as an RN, CN, NUM and CNC. Her areas of interest are standards and practice, leadership and patient safety.

"We are uniquely positioned as advocates for patients and our professions, to participate in strategic planning, delivery of health services and policy development whilst ensuring growth of the professions."

Ms Jones uses her professional and union roles at every opportunity to promote and protect nursing and midwifery.

James Lloyd joins the team as ANMF Federal Vice President. Mr Lloyd is a registered nurse with 25 years' experience, largely at the Royal Hobart Hospital. He specialised in neuroscience and intensive care before he became an After Hours Nurse Unit Manager.

In 2011, Mr Lloyd was elected to the ANMF Tasmanian Branch Council. He has been a member of Branch Executive, elected Vice President and is currently President. He has been actively involved in public enterprise bargaining, media, as well as more broadly representing the ANMF at the RHH.

"I look forward to representing Tasmania in the federal sphere. We have similar issues in Tasmania as the rest of Australia, such as ED ramping. We are also unique with our own health challenges. We have relative geographical isolation and relatively high heart disease with an ageing population."

AUSTRALIAN DEMENTIA NETWORK LAUNCHED

A new large-scale national registry and research program is aiming to fast-track dementia research in Australia in a bid to drive better care and support for all people impacted by the progressive disease.

Launched last month, the federal government backed Australian Dementia Network (ADNet) introduces an integrated registry of researchers, studies, information, data and clinicians to ensure more targeted, effective research.

Specifically, ADNet will create a national network of memory clinics to speed assessment of cognitive disorders and improve specialist access; provide participants of clinical trials with state of the art diagnosis; and collate and compare data to chart dementia causes, progressions, risks and potential new treatments.

ADNet will also ensure Australian and international data is shared, providing unprecedented research access to global data and collaboration to inform prevention, treatment and care.

About 1,700 Australians per week join the population living with dementia and without breakthroughs the figure will rise to 650 per day by 2050.

Dementia is already the biggest killer of Australian women and the second most

common cause of death among the entire population, claiming over 13,000 lives each year.

ADNet will drive research and deliver improvements through five core teams – Registry, Clinics, Trials, Technology and Business – forming close links to leading international programs in Europe and the USA.

Dementia Australia CEO Maree McCabe welcomed the federal government's \$18 million commitment to help people impacted by dementia.

Ms McCabe said a more comprehensive and integrated picture of clinical research would help pinpoint the characteristics of dementia.

"ADNet will enable dementia researchers, clinicians, health service providers, industry and, most significantly, people living with dementia, their families and carers to work smarter together to provide better care for now, and for a future cure," Ms McCabe said.

"Combining forces will also better position Australian dementia researchers internationally to contribute more effectively and with more clarity to the global puzzle of dementia."



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ASSISTED SUICIDE BILL UP FOR DEBATE

A Bill that would give the Northern Territory and Australia Capital Territory the power to make laws on euthanasia is set for debate in Federal Parliament this month.

In June, Liberal Democrats Senator David Leyonhjelm put forth a motion to allow a conscience vote on his Restoring Territory Rights (Assisted Suicide Legislation) Bill, gathering solid support from several Greens, Labor and Crossbench senators.

A debate will now take place in the Senate on 14 August.

The push effectively repeals the 'Andrews Bill' of 1997, which prohibited the ACT and NT from legislating euthanasia after it became the first jurisdiction in Australia to introduce assisted dying under the Rights of the Terminally Ill Act 1995, which allowed terminally ill Territorians the right to end their own lives.

As a result, the ACT and NT lost the power to make laws on voluntary assisted dying, despite all other states currently being able to do so.

If successful, the latest development will allow the ACT and NT to regain control from the federal government over being able to legislate assisted suicide.

"My Bill addresses two issues: territory rights, and the right to die. I am a firm believer in both," Senator Leyonhjelm said.

"I believe in the right of individuals to end their lives painlessly at a time of their

choosing, as do the majority of Australians. The Commonwealth should mind its own business on the issue and remove legal impediments to states and territories establishing their own legislation."

Last November, Victoria became the first state to pass voluntary assisted dying laws, giving terminally ill Victorians greater choice and control in their final days from 2019.

To be eligible, a person must be over 18, have lived in Victoria for at least a year, and be diagnosed with a terminal disease causing intolerable suffering that is expected to cause death within six months.

Similar attempts to legislate voluntary assisted dying have been made in Tasmania, South Australia and New South Wales in recent years only to be narrowly defeated.

The Australian Nursing and Midwifery Federation (ANMF) has advocated for legislative reform to give people suffering terminal illnesses the right to die with dignity in a manner acceptable to them.

DOMESTIC AND FAMILY VIOLENCE COMMON AMONG FEMALE HEALTH PROFESSIONALS

A landmark study examining the prevalence of domestic and family violence among female health professionals, including nurses and midwives, has revealed nearly half have experienced violence during their lifetime and that one in 10 were abused by their partner during the past year.

Published in the *BMC Women's Health* journal, the study surveyed 471 nurses, midwives, doctors and other health professionals in a bid to address a gap in the available evidence regarding the rate of domestic and family violence against female health professionals in Australia.

Carried out at a large Australian tertiary maternity hospital, the survey yielded 471 participants, including 172 midwives and 145 nurses.

It uncovered 45% of participants had experienced violence at the hands of a partner or family member across their lifetime, including one in 10 female health professionals who reported being raped by a partner since the age of 16.

The most common form of domestic violence over the past year was emotional abuse/harassment.



Lead researcher Elizabeth McLindon, from the University of Melbourne and Royal Women's Hospital, said the study raised important considerations given health professionals increasingly provide frontline support to patients experiencing domestic and family violence.

"For some workers, it may result in them going the extra mile in supporting survivor patients, but for some women, it could also trigger personal trauma to hear stories of other people's experiences of violence," Ms McLindon said.

"Hospitals have an important role to play in supporting their healthcare workers to ensure their wellbeing is not negatively impacted by their day to day work."

The study found intimate partner and family violence, including sexual assault, to be common traumas in the lives of female health professionals.

It concluded the problematic issue must be tackled by improving health workplace policies and protocols, including introducing workplace manager training to respond to disclosures from staff, special

leave provisions, and implementing staff counselling services.

"Health services should have safe pathways to care for both health professionals and patients who are experiencing intimate partner and family violence," the study read.

Study co-author Professor Kelsey Hegarty, Director of the Centre of Family Violence Prevention at the Royal Women's Hospital and Professor at the University of Melbourne, believes the study shines the spotlight on the harsh reality that domestic and family violence affects all women in the community, even those with high education and financially secure employment.

"As women who experience violence are much more likely to experience depression and anxiety, self-harm and suicide attempts, sleeping and eating disorders, lower self-esteem and alcohol and other drugs misuse compared to women who live free from violence, it is crucial that healthcare staff are supported to have access to services that assist them in their experience of family violence," Professor Hegarty said.

SUGAR REDUCTION PLAN LACKS TEETH

Health groups have dismissed a federal government-supported plan to cut sugar by 20% as an attempt to stave off a regulatory imposed sugar tax.

The Australian Beverages Council last month announced it would reduce sugar use by 20% by 2025.

The Australian Beverages Council is the peak body that represents the non-alcoholic beverage industry which includes Coca-Cola, Pepsi, Asahi and Frucor.

The federal government was quick to endorse the soft drink industry's commitment in an announcement at Parliament House. Federal Health Minister Greg Hunt said it was a clear sign the industry was taking additional steps to support healthy initiatives.

The announcement came under fire from health groups for the lack of real reform.

"Clearly the sugary drinks industry is proposing this voluntary package of measures in an attempt to resist the tide of regulation that is happening around the world," Public Health Association Australia (PHAA) CEO Terry Slevin said.

For example, a 375ml can of Coke contains around 10 teaspoons of sugar. A 20% reduction would lower this to eight teaspoons of sugar.

"This is hardly a significant reduction in sugar content," Mr Slevin said. "This is a weak attempt at appearing to address the damage they are doing to the public's health. It's not nearly enough to make any impact on



the enormous burden of disease contributed by consumption of these drinks."

The target of implementing the reduction by 2025 was even questionable, according to the PHAA. The announcement in the UK recently to introduce a health levy on sugary drinks had resulted in industry reformulating their products before the tax was introduced.

Rethink Sugary Drink Alliance spokesperson Craig Sinclair said the soft drink industry's commitment would be measured on aggregated sales volume rather than reformulation of products.

"A company could reduce its use of sugar simply by producing and selling more low-kilojoule soft drinks or bottled water."

Mr Sinclair said it was clearly a pre-emptive move by the industry to delay further discussion about a health levy on sugary drinks.

Evidence from many countries, which had introduced a tax on sugary drinks, had shown it worked, Australian Dental Association Victorian Branch President Dr Kevin Morris said.

"The UK model has been even more effective, with manufacturers reformulating products to actually remove sugar from drinks.

"It is disappointing that the federal government is not prepared to step up and show some real leadership on this issue."

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AUSTRALIA WINS RULING ON TOBACCO PLAIN PACKAGING LAWS



Australia has scored a landmark victory in a World Trade Organization (WTO) dispute over whether its pioneering tobacco plain packaging laws are a necessary public health measure and consistent with WTO international trade and investment rules.

Four countries – Indonesia, Cuba, Honduras and the Dominican Republic – had argued that Australia's plain packaging laws go against its rules, infringed tobacco trade-marks and violated intellectual property rights, and that alternative measures would be equally effective.

In late June, a WTO panel ruled in favour of Australia, saying the country's plain packaging laws contributed to improving public health by reducing tobacco use and exposure.

The Public Health Association of Australia (PHAA) welcomed the WTO's decision and said it signalled growing international recognition of the health benefits of plain packaging.

"The tobacco industry had fought this reform at every possible corner," PHAA CEO Terry Slevin said.

"Largely because they are concerned about the impact it will have on their capacity to recruit new users for their deadly products."

The WTO's ruling is expected to prompt other countries to adopt similar laws.

Mr Slevin commended both sides of Australian politics for their stance on the issue, as well as the Cancer Council Victoria, which committed significant resources to researching, promoting implementation and defending plain packaging.

Statistics in the recent *Australia's Health 2018* report released by the Australian Institute of Health and Welfare showed smoking rates among Australian teenagers dropped from 5% in 2013 to 2.1% in 2016.

"This is a public health reform all Australians can be proud of. We are a world leader in tobacco control and most importantly, this means the health of the Australian people is better protected from the harms caused by tobacco," Mr Slevin said.

INDIGENOUS AUSTRALIANS FACE HIGHER MENTAL HEALTH BURDEN

Indigenous Australians are four to seven times more likely to experience mental health disorders than non-Indigenous Australians, new research from the University of Queensland (UQ) shows.

Undertaken by the UQ Rural Clinical School, the study examined the prevalence of common mental health disorders in Southern Queensland and two Aboriginal communities in New South Wales.

Disorders were broken down into three general groups – mood, anxiety and substance abuse disorders – with face-to-face interviews revealing Indigenous Australians are 6.7 times more likely to suffer mood disorders, 3.8 times more likely to experience anxiety and 6.9 times more likely to have substance abuse disorders.

The study also revealed rates of mental illness were much lower among Aboriginal Reserve and remote area residents, suggesting the importance of Indigenous peoples' connection to their traditional lands and culture.

The school's Director of Indigenous Health, Dr Maree Toombs, said the findings exceeded estimates.

"These findings have given us a picture



of how big the problem is so we can start advocating for change," Dr Toombs said.

Professorial Research Fellow Professor Geoff Nicholson said evidence showed people with mental illness were more likely to have chronic physical illnesses and die prematurely.

"We think the contribution of mental illness to the Indigenous Health Gap and increased mortality has been grossly underestimated," Dr Nicholson said.

"Dislocation from traditional homelands, kinship networks and family, together with poverty, violence, marginalisation and racism are all significant risk factors which need to be addressed for the gap to be closed."

The study team has received a National Health and Medical Research Council (NHMRC) grant to develop a treatment program based on its findings with the aim of specifically targeting affected communities.

HEALTH PRIORITIES FOR PEOPLE IN THE BUSH

The Royal Flying Doctor Service (RFDS) of Australia has been caring for country people for 90 years. It is expected that as the Australian population ages, the prevalence of chronic disease will increase, and that there will be substantial service provision gaps in the bush.

As a nurse and/or midwife in the field, the RFDS would like to know what you think are the most important areas of clinical need in the bush. To find this out, they would like to invite you to complete a brief online survey. If you are 18 years of age or older and a health professional currently treating rural and remote patients, we invite you to participate in this survey. It should take about 10 minutes of your time.

Your responses are voluntary and will be confidential. Individual responses will not be identified and you can skip questions. All responses will be compiled together and analysed as a group.

We will release a public report on what we find in late October 2018.

The survey can be accessed via: surveymonkey.com/r/X82VFR3

If you have any questions about this survey, please call Dr Fergus Gardiner at the RFDS on 02 6269 5512 or email him on Fergus.gardiner@rfd.org.au



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MENTAL HEALTH APPS COULD LEAD TO OVERDIAGNOSIS

Mental health app marketing, which sells mental health issues as being widespread and places the responsibility for wellbeing on individuals, could be leading to overdiagnosis and harm, new research from the University of Sydney shows.

Researchers aimed to identify how the advertising materials for popular mental health apps frame mental health and what the apps offer around diagnosis and management.

They assessed the advertising material of 61 prominent mental health apps available in Australia, the USA, UK and Canada during 2016, focusing on apps that explicitly referenced mental health diagnoses or symptoms and offered diagnosis, guidance or made health claims.

Two dominant messages about mental health emerged – poor or fragile mental health is ubiquitous and individuals can easily manage their own mental health problems with apps.

Lead author Dr Lisa Parker, a Postdoctoral Research Associate with the University of Sydney's Charles Perkins Centre and School of Pharmacy, said the findings created cause for concern.

"Implying mental health problems are present in everyone promotes the medicali-



sation of normal states," Dr Parker said.

"The apps we assessed tended to encourage frequent use and promoted personal responsibility for improvement.

"The idea that the normal ups and downs of everyday life need treatment could drive use of these apps by people with minor concerns. These users are unlikely to get any significant benefits but may receive large time burdens and potential loss of privacy."

Dr Parker suggested it would be beneficial to promote alternative views to consumers about what constitutes normal psychological experiences in order to prevent overdiagnosis.

Further, she said people with severe mental health issues could be assisted by GPs or mental healthcare workers discussing

the limitations of using such apps and the importance of seeking additional forms of supportive healthcare when required.

Senior author Dr Quinn Grundy, from the Charles Perkins Centre and Faculty of Pharmacy, agreed saying healthcare professionals had a responsibility to counter misplaced messages some of these apps provide.

"The smartphone is one of the most powerful tools for communication and apps have the potential to increase users' social supports," Dr Quinn said.

"Yet popular mental health apps focus largely on individual self-help solutions and personal responsibility. This creates a great deal of silence around external and social factors related to mental health."

FUNDING BOOST FOR MENTAL HEALTH SUPPORT

Australians experiencing severe mental health illness currently unsupported by the National Disability Insurance Scheme (NDIS) will receive greater care in their communities following a joint \$160 million funding injection from the federal government and states and territories.

The federal government has pledged \$80 million over four years, with each state and territory government matching the funding commitment.

Funding will be allocated to each jurisdiction on a population basis and the initiative, which began last month, will be delivered through Primary Health Networks.

For example, Tasmania will receive \$1.7 million over the four-year period.

The national psychosocial support measure is aiming to fill the gaps in supporting people with severe mental illness currently ineligible under the NDIS who would benefit from specialised but less intense psychological services such as individual and group assistance and rehabilitation.

Psychosocial support services could include a range of non-clinical supports such as vocational and social skills training, finding and maintaining a home and drug and alcohol addiction support.

"This psychosocial support is helping those most in need get the support in their

own community," Federal Health Minister Greg Hunt said.

"It delivers vital services to people where they need it and when they need it."

Mental Health Australia welcomed the funding announcement, calling it an important step forward in reaching people with mental illness at risk of being left without support.

Mental Health Australia CEO Frank Quinlan said about 780,000 people experience mental illness but just 64,000 have a place in the NDIS.

He said while the NDIS supported people in the community with the most severe forms of mental illness there had been significant concern about the lack of attention to others in broader society.

He commended the federal government's move in responding to the concerns of the sector, consumers and carers.

"We know that without these services, provision of support inevitably falls to unpaid family members and loved ones," Mr Quinlan said.

REAL-TIME PRESCRIPTION DRUG MONITORING SYSTEM LOOMS

Victorian nurse practitioners, doctors and pharmacists are set to get access to up-to-the-minute information on the prescription histories of their patients when innovative system SafeScript begins operation in October.

New laws came into effect last month allowing data to be collected when SafeScript goes live later this year, ensuring clinicians can monitor their patients' use of prescription drugs in a bid to reduce growing harm.

Statistics show that in 2016 there were 372 drug overdose deaths in Victoria involving pharmaceutical medicines, higher than the number of overdose deaths caused by illicit drugs (257) and the road toll (291).

Prescription medicines to be monitored through SafeScript include morphine, oxycodone, alprazolam, and some Schedule 4 medicines such as diazepam.

Codeine was recently also added to the list of medicines to be monitored from the start, instead of being added later, as had been originally recommended by the SafeScript Expert Advisory Group.

Experts have been monitoring the impact of recent changes that made codeine 'prescription only' and concluded it needed to be added to the list.

The Victorian government provided \$29.5

million to implement SafeScript, which will leverage electronic prescription exchange services to obtain prescription data for the system.

The prescription exchanges currently support the electronic transfer of prescriptions between doctors and pharmacists when medication is dispensed to patients.

Victorian Health Minister Jill Hennessy said the new system would help give clinicians the resources they needed to monitor patient prescription drug use and save lives.

The system will be accompanied by a range of initiatives to help support patients and health professionals through the transition including a public awareness campaign and training for prescribers and pharmacists.

"Too many Victorians have died from the misuse of prescription medicines. This is an avoidable tragedy and that's why we're getting SafeScript done to fix it."

ROYAL FLYING DOCTOR SERVICE TARGETS MENTAL HEALTH IN RURAL AND REMOTE

The Royal Flying Doctor Service will use \$84 million it received in

May's federal Budget to expand its existing services and establish a mental health outreach program for Australians living in rural and remote areas.

The iconic service has been around for 90 years and provides extensive primary healthcare and 24-hour emergency response to people over the country's vast expanses.

This includes regular fly-in-fly-out GP, Nursing and Allied Health Clinics to rural and remote communities.

The latest funding has allowed the vital service to launch a new Mental Health Outreach program, beginning in January

2019, that will provide professional mental health services to rural and remote areas in need.

In the past year alone, the Royal Flying Doctor Service cared for 335,000 Australians in the air, on the ground, or via telehealth.

Rural Health Minister Bridget McKenzie said the Royal Flying Doctor Service provided crucial access to primary healthcare services for people living and working in rural and remote Australia.

"We know that Australians living in regional areas often have limited access to essential services and support that those in metropolitan cities take for granted," Ms McKenzie said.



TAKING CONTROL OF LYNCH SYNDROME – AUSTRALIA'S FIRST NATIONAL SYMPOSIUM

Lynch Syndrome Australia (LSA) will host the inaugural National Lynch Syndrome Symposium in Sydney this month.

Lynch Syndrome (LS) is Australia's most prevalent inherited cancer risk but it is relatively unknown. It affects tens of thousands of Australian families who have no idea that they are at risk.

LSA is the only national advocacy group that represents Australians diagnosed with LS and their families. LS is an inherited gene fault that predisposes the carrier to multiple, primary cancers from a young age. LS is Australia's most prevalent cancer-causing gene mutation and it is conservatively estimated by epidemiologists that 1:250 Australians (approximately 100,000 people) have one of the identified mutations in a cancer repair gene. It has been estimated

that around 4,000 cancers in Australia each year could be LS-associated.

The symposium will examine and challenge the main medical, systemic and behavioural barriers to improving diagnosis, treatment and care for the tens of thousands of Australians living with LS and showcase best practice, latest research and innovations in minimising cancer risks.

This is a one-stop shop for information, solutions and hope for Australians living with Lynch Syndrome, their families and those professionals and academics who support them.

The symposium will be held on 30 August at Garvan Institute of Medical Research, Sydney.

For further information including registration details visit lynchsyndrome.org.au/taking-control-surviving-and-thriving-symposium/

DRAMATIC DROP IN HAND HYGIENE COMPLIANCE WHEN NOT OBSERVED

Healthcare worker compliance with national hand hygiene guidelines falls from more than 90 to 30% when they are not being observed, latest research shows.

The national mandatory hand hygiene program was introduced in Australian hospitals eight years ago and requires a 70% compliance rate.

The University of NSW (UNSW) study monitored human and automated methods of hand hygiene surveillance in an Australian teaching hospital over a period of two years.

Automated surveillance included hand hygiene dispensers at sinks and bedsides recording hand hygiene by touch. Human surveillance was direct observation of healthcare workers by human auditors.

Lead author UNSW Medicine Professor MaryLouise McLaws, an infection control expert and World Health Organization health adviser said it was the first study to look at errors in compliance rates since the national

hand hygiene program was introduced in 2010.

"We found that as soon as human eyes were off the clock outside of the mandatory 20-minute audit and our automated method continued to monitor compliance, hand hygiene compliance went from 94 to 30% - which is gravely concerning.

"The government has been telling us that compliance is high. Our study shows that this may not be the case."

Healthcare workers were good at hand hygiene compliance when there was perceived risk to themselves including exposure to body fluids, or to patient safety. However hand hygiene compliance before patient contact and in patient zones, including tables, lockers, curtains and door handles was poorer, Professor McLaws said.

"At the moment, clinicians are more likely to practice good hand hygiene after contact than before, due to a perceived need for self-protection, so their attitudes need to be challenged."

Professor McLaws said that just telling very busy, overworked nurses and doctors that they were required to adhere to hand hygiene guidelines was not the same as changing behaviour.

"A national behaviour change program needs to be implemented, such as getting back to basics by focusing on mandatory compliance before every patient contact."

Cultural change and deep behavioural issues needed to be addressed from childhood, she said.

"For my generation hand hygiene was very important with the eradication of polio. We worry about hand hygiene with coughs, colds and the flu but we do not consider hand hygiene the cornerstone of public health that protects us all."



QUEENSLAND POISED TO VOTE ON DECRIMINALISING ABORTION



The Queensland government is set to introduce draft legislation into the state's Parliament this month that would decriminalise abortion and allow women safe access to the procedure.

The reform would remove abortion from the state's Criminal Code, in place since 1899, which stipulates any woman who illegally has an abortion in Queensland can be sent to prison for up to seven years, and that anyone who unlawfully performs an abortion can be jailed for up to 14 years.

The draft legislation will enter Parliament this month ahead of debate in October, with the Labor government signalling it will give its MPs a conscience vote on the contentious issue.

Under the proposed laws, pregnancies will be allowed to be terminated in the first 22 weeks, and thereafter with the permission of two doctors.

Other clauses include doctors being able to object to performing the procedures on moral grounds, while a 150-metre safe access zone will be implemented around abortion clinics to block protesters from approaching entrances.

If the new Bill passes through Parliament, abortion will no longer carry the threat of jail time and instead be considered a health issue.

The overhauling of abortion laws was triggered by a Queensland Law Reform Commission (QLRC) review, which recommended legalising the procedure in Queensland.

Abortion in Australia is subject to state law, with every other state bar New South Wales having removed abortion from its Criminal Code.

The Queensland Nurses and Midwives' Union (QNMU) made a submission to the QLRC review that stated women should have access to legal and safe abortion, counselling services before and following a termination, and information and services to support adoption or maintaining a pregnancy.

It has also recommended the Queensland government, together with the federal Department of Health, implement a broad female sexual and reproductive health strategy that includes access to education, services and counselling.

Following last month's announcement, the QNMU backed the Queensland government's decision to legalise abortion, with Branch Secretary Beth Mohle agreeing the draft legislation would support the health and wellbeing of women across the state and protect those who performed and assisted in the procedure.

"The QNMU believes women should have access to legal and safe abortion and that the legalisation or regulation will help reduce harm to the individual and those who

perform or assist with the procedure," Ms Mohle said.

Ms Mohle acknowledged a range of views existed on whether abortion was ethically acceptable and asked members to respect the union's position.

"We ask that those with a different view also respect ours."

Queensland's historic move was welcomed by the Human Rights Law Centre, which said the development offered an opportunity to bring the state's abortion laws in line with "contemporary medical standards" and "modern community values".

The not-for-profit organisation protects and promotes human rights in Australia and pointed to polling in Queensland in 2017 showing more than 80% of people supported a woman having the right to terminate her pregnancy in consultation with a medical professional.

"It's absolutely shameful that in 2018 a woman and her doctor can still be imprisoned for seeking a safe medical procedure," Adrienne Walters, a Senior Lawyer at the Human Rights Law Centre said.

"Criminalising abortion just causes confusion and fear. It forces women to travel interstate or risk unsafe clandestine abortions. The law should support all people to make the best possible medical decision for their health."

FUNDING BOOST TO TACKLE HOMELESSNESS

Victorian families experiencing homelessness, particularly nurses, midwives and carers, will have greater access to social housing thanks to a \$7 million grant commitment by the ANMF (Vic Branch) to Melbourne-based housing support agency Launch Housing.

Announced at the annual ANMF (Vic Branch) Delegates Conference in June, the grant will be spread over the next two financial years and allow Launch Housing to develop projects to support Victorians struggling to access and maintain housing.

Half of the grant will go toward Launch Housing's Families Supportive Housing Project in Dandenong and involve the construction of 60 two to four-bedroom units to provide homes for families.

Launch Housing will also collaborate with not-for-profit organisation Wintringham to

build housing in regional Victoria to ensure the ANMF (Vic Branch) is delivering both metropolitan and regional assistance.

ANMF (Vic Branch) Secretary Lisa Fitzpatrick said the branch holds a strong commitment to social justice and that the grant is the result of seeking to contribute positively to the lives of less fortunate Victorians.

The ANMF (Vic Branch) retains active leadership within the homelessness sector from members who worked for the RDNS Homeless Persons Program (HPP) (now Bolton Clarke), she added.

"We believe it is incumbent on us to make Victoria a better place," Ms Fitzpatrick said.

"The very nature of our work means we meet patients whose lives are changed in an instant – family violence or a serious physical illness or injury or a mental health issue can lead to a series of events that can lead to homelessness. Nurses, midwives and carers are not immune to these life events.

"We also know that through relationship breakdown, family violence and workplace injury, the group of people vulnerable to homelessness significantly on the increase is women over 55 years."

Launch Housing CEO Heather Holst described the funding boost as uplifting and commended the ANMF (Vic Branch) for their crucial support.

"We have 16,000 people a year coming to us for assistance after either new housing

because they haven't got any or they've got to move," Ms Holst explained.

"Being able to build something, purpose-designed and targeted at people who are coming out of homelessness is just fantastic."

Ms Holst said Launch Housing recently conducted a survey examining the people who use its services and found evidence of current or former nurses, midwives and carers accessing help.

As part of the projects, she said nurses, midwives and carers would be given first opportunity to acquire available housing before it is then offered to others experiencing homelessness.

Ms Holst said the complex homelessness problem deserved far greater attention and required collective action.

"It's the Australian housing market, first and foremost," she said of the main drivers.

"The way we work it in Australia you've got people who do very well out of that and people who do very badly, even to the point of being pushed into homelessness. We've got to somehow equalise our housing market a lot more and make it more about shelter than an investment.

"We need a better coordinated response, which we're working on hard, and we need to have housing that is reserved for people who are homeless and not housing that they have to compete with alongside better able people."

NEW LEGISLATION TO MINIMISE IMPACT OF MEDICINES SHORTAGES

The introduction of legislation requiring the mandatory reporting of medicines shortages by pharmaceutical companies is aiming to improve the management of medicines supply to Australian hospitals and improve patient outcomes.

Federal Health Minister Greg Hunt introduced the Therapeutic Goods Amendment (2018 Measures No 1) Bill 2018 in late June, amending the Therapeutic Goods Act 1989 to for the first time define a medicine shortage in Australia.

The definition states a shortage exists when the supply of a medicine, for a six month period, 'will not, or will not be likely to, meet the demand for the medicine for all of the patients in Australia who take, or who may need to take, the medicine',



Kristen Michaels, Chief Executive of The Society of Hospital Pharmacists of Australia, said a nationwide system for managing and communicating medicines shortages through the Therapeutic Goods Administration (TGA) would improve patient outcomes.

Ms Michaels said hospital pharmacists had called for more rigorous and systematic medicines supply management for some time.

"Once passed into law, the new protocol will make a huge impact on the effectiveness of hospital pharmacists in Australia,

liberating their time to spend on crucial face-to-face cognitive pharmacy services on the ward, maximising their input into multidisciplinary medical teams."

Ms Michaels added the prioritising of medicines used to treat acutely ill patients in hospitals through the Medicines Watch List would help reduce the amount of time hospital pharmacists spend seeking alternative or replacement medicines.



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A healthcare professional, a woman with dark hair and glasses wearing blue scrubs, is pointing at a tablet held by an elderly woman with short grey hair. The elderly woman is wearing a grey cardigan over a pink lace top and dark pants. They are standing in a bright, modern hospital corridor with large windows in the background. The scene is overlaid with a blue gradient at the bottom where the title text is located.

NEW ERA IN ELECTRONIC HEALTH



All Australians will have a *My Health Record* created unless they chose to opt out by 15 October. The record is a summary of key health information which will be made available to health practitioners in relation to the care of their patients. Experts believe the technology will provide better coordinated and safer care. **Cathy Beadnell** investigates the benefits of *My Health Record* and how nurses and midwives will be involved.

Aboriginal elder Uncle Merv (Mervyn Brown) is a big fan of *My Health Record* and is happy to talk about why to other elders and community members who attend IPC Health programs in the outer western suburb of Werribee in Melbourne.

His support for the initiative is so strong that Uncle Merv and three of his great grandchildren feature in a promotional poster developed by the North Western Melbourne Primary Health Network aimed at encouraging uptake of the electronic health record.

Uncle Merv is approaching 80 years of age and has complex and chronic health issues so he knows all too well the benefits of having his health record available to a range of health practitioners who help him stay well.

"I've had two cancer diagnoses in the last few years. I'm in remission now from prostate cancer and I've also got spinal carpal stenosis," Uncle Merv says. "I think the *My Health Record* is a great invention because if I go to Sydney or somewhere and something happened to me I would like the healthcare professionals to get straight on to it."

Uncle Merv is only too aware of the current fragmentation of Australia's healthcare system and the benefits a nation wide electronic health record could bring to the coordination of care and the outcomes that it will deliver to patients.

"I know myself that I have to repeat things about my health to different specialists and I don't always remember what information I should share with everyone," he says. "I feel confident now that the *My Health Record* will let the doctors and nurses access the information they need. They will have my medical history in front of them instead of me

trying to tell them everything. If everything is correct and in order they will know the best way to treat me."

Uncle Merv is just one of a growing number of Australians who need a high level of coordinated healthcare to treat complex and chronic health conditions. As the population ages the level of complexity in health conditions increases and the need to manage the healthcare of the population presents enormous challenges.

Community health nurse Alex Rojas runs the elders lounge program that Uncle Merv attends. She says an electronic health record will benefit health professionals and consumers of health services alike.

"People are living longer, and their healthcare needs are becoming more complex due to increasing chronic disease and co-morbidity," she says. "So, an integrated and connected healthcare system is essential for the treatment and management of these conditions."

Alex says Uncle Merv's support of *My Health Record* is helping promote the initiative in the local Indigenous community.

"Uncle Merv is genuinely committed to spreading the word about the importance of having health information available for treating health professionals and taking individual control of your own healthcare," she says.

One of the greatest benefits an electronic health record brings to patients is the ability to participate actively in the management of their own healthcare. In addition to reducing the need for duplication of tests and better coordination of care for those with chronic and complex conditions, patients can make more informed decisions on treatment.

Consumers Health Forum CEO Leanne

MY HEALTH RECORD IS A KEY STEP IN THE SHIFT FROM HEALTH CONSUMERS AS PASSIVE PATIENTS TO CONSUMERS AS ACTIVE PARTNERS IN THEIR OWN CARE

Wells says the electronic health record will give Australians more control over their healthcare decisions.

"My Health Record is a key step in the shift from health consumers as passive patients to consumers as active partners in their own care," she says.

"For too long healthcare has lagged behind in exploiting the clear benefits of information technology to provide prompt, secure and precise patient information. For these benefits to be realised and a consumer-centred and digitally enabled healthcare system to become a reality, consumers will need to be involved in using and improving innovations such as My Health Record."

Uncle Merv says having an electronic health record makes you feel like you're in control. "You can keep up with your own healthcare through the app. Things like having your allergies and all of that history on the record reduces the risk of being given the wrong medication if something unexpected happens and you find yourself in hospital."

Australia is catching up with advances in electronic health and is committed to a universal electronic health record by the end of 2018. Almost six million Australians have

already signed on to My Health Record and unless an individual chooses to 'opt out' of the scheme between 16 July to 15 October 2018, they will automatically be enrolled.

Consideration of introducing an electronic health record in Australia began to take shape in 2000 and was finally introduced under a Federal Labor government in 2012. The first e-health record was titled 'Personally Controlled Electronic Health Record' (PCEHR) and is now referred to as My Health Record.

The 2017 Budget included \$374.2 million over two years to expand Australia's digital health system and the Australian Digital Health Agency is ramping up efforts to build the nation's technological infrastructure.

In May this year the federal government made clear its intention to rapidly expand uptake of electronic health records in the Australian community. The key element of the plan is the change of direction from an opt in to an opt out process.

A 2016 trial of an opt out scheme took place in northern Queensland and the Blue Mountains region of NSW. The trial was an overwhelming success with 970,000 records created. Only 1.9% of participants of the trial chose not to adopt an electronic health record.

The current national opt out plan has widespread support across health professions with endorsement from the Australian Nursing and Midwifery Federation, Australian College of Nursing, Australian Medical Association, the Royal College of Australian General Practitioners, Pharmacy Guild of Australia, Australian Primary Health Care Nurses Association, and the list goes on.

ANMF Federal Professional Officer Julie Reeves says an opt out scheme is the best way to achieve a critical mass of participants to bring Australia into the digital age in healthcare.

"The ANMF has supported an opt out system for uptake of the My Health Record for a long time. We need to get enough

people signed into the scheme to see the benefits," she says. "The more people who use it the more benefit patients and healthcare professionals will see from it. Nurses and midwives support it because it improves availability and quality of health information and makes our job more streamlined and accurate with timely information."

Julie Reeves says one of the greatest benefits for health professionals and patients of an electronic health record is the sharing of patient information across healthcare settings.

"The electronic record improves health by increasing communication across systems. If you are a nurse working in an aged care setting and a resident requires a hospital admission, the electronic record will make it much easier to identify the outcomes and ongoing care needs of that person when they are discharged and return to your care," she says.

"With all of the information stored on a patient's My Health Record a nurse or midwife will be able to access their record and have the information and experience of the person they are caring for, at their fingertips. If a resident is returning from an acute setting to aged care the nursing staff will be able to see what medicines have changed, for example, and ensure continuity of care."

Nurses and midwives are early adopters of technology in the healthcare system and the ANMF has been at the forefront of developing professional standards and guidelines in the use of information technology.

A 2007 study by the then ANF highlighted the need for nurses and midwives to have a high level of informatics education in the curriculum. With electronic communication technology becoming the standard method of recording and sharing patient information across health and aged care settings, nurses and midwives required the necessary resources and education standards to inform practice.

The 2007 study found 85% of nurses and midwives at the time used a computer for some aspect of their work. Undergraduate nursing and midwifery education now incorporates digital literacy and e-learning into every unit of study according to student Bridget Loats.

Bridget is in the third year of a nursing and midwifery degree at Deakin University in Melbourne.

She says the course requires a digital literacy learning outcome in every unit of study.

"I think the standard of digital literacy in my double degree course at Deakin is very high. We have to demonstrate a high level of computer literacy and the ability to analyse data and find evidence to back up our research projects," Bridget says.

"As a student I would say there is one area for improvement and that is when we are on placement we are often unable to access hospital systems. This might be a security risk but it doesn't seem to be consistent. Some students are able to have limited access in some hospitals but we usually have to



UNCLE MERV AND HIS GREAT GRANDKIDS
PHOTO COURTESY OF THE NORTH WESTERN
MELBOURNE PRIMARY HEALTH NETWORK.



THE ANMF NATIONAL INFORMATICS STANDARDS

DOMAIN 1: COMPUTER LITERACY

Applies knowledge and skills in computer basics for effective use of information and communication technologies.

DOMAIN 2: INFORMATION LITERACY

Uses fundamental knowledge and skills to identify, locate, access, evaluate and apply information

DOMAIN 3: INFORMATION MANAGEMENT

Uses knowledge and skills to ensure safe, legal and ethical management of health information for professional practice and lifelong learning, appropriate to context of practice.

ask the nurse on duty to help us access or show us a patient's record. It would be really good to have access to patient information that is relevant to our placement and gain experience in using the different IT systems in hospitals."

The Health Informatics Society of Australia represents Australia's digital health community including Nursing Informatics Australia (NIA).

The NIA agrees that informatics education is essential for nurses and midwives. Their 2017 position statement, issued in partnership with HISA and the Australian College of Nursing says 'Education in nursing informatics is essential in all undergraduate and postgraduate nursing programs. Moreover, the workplace must provide education in health informatics to all nursing staff not only at induction but as part of continuous learning'.

Nurses and midwives are the largest group of Australia's healthcare professionals and the ANMF says they will play a leading role in the

implementation of My Health Record. "Nurses will be at the forefront of helping people set up their e-health records and will also use the information and data to inform our practice and research," says Julie Reeves.

"A really important issue in the roll out of My Health Record will be managing the workload for nurses and midwives and making sure they are adequately resourced to play a critical role in implementing the initiative for millions of Australians into the future."

This argument is also backed up by the NIA's position statement on nursing informatics which says: 'Organisations, irrespective of size or setting, transitioning to digital health records to have an appropriately sized team responsible for informatics and nursing engagement that can facilitate partnerships with other disciplines and function as strong advocates for consumers. The team will be primarily responsible for embedding change into clinical workflow as well as provide governance oversight. This is to safeguard effective adoption and optimisation of clinical information systems'.

The ANMF's Julie Reeves says nurses and midwives will use the data generated by electronic health records to improve research and practice. "We will be able to access good quality information and be able to analyse the data with the aim of improving health outcomes for people who require care."

While benefits of e-health are apparent for patients and healthcare professionals the issue of data security remains an area of

concern for many in the healthcare sector and in the community.

Julie Reeves says the ANMF is overwhelmingly in favour of the comprehensive roll out of My Health Record. However she says health professionals and consumers must have trust in the system and the digital agency needs to ensure personal data is secure.

"Work is needed to ensure any digital platform and healthcare information is secure. This involves establishing agreed national guidelines on how data is collected, stored and shared. "Systems need to also protect health professionals by ensuring their information is not compromised. The allocation and security of electronic healthcare professional's signatories is an important example of the need for this protection."

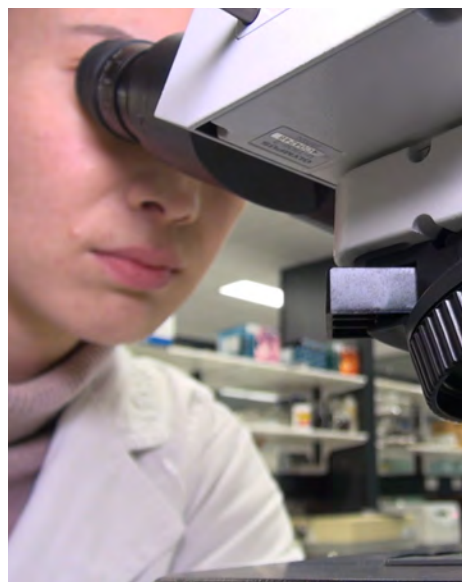
Australian Digital Health Agency CEO Tim Kelsey says individuals will control the content of their health record including the ability to restrict access to specific information in their records.

"Strict privacy control, set by an individual, is a central feature of My Health Record. Each person can control the information in his or her record, and the healthcare provider organisations that can have access."

Uncle Merv takes a more relaxed attitude to security concerns in relation to My Health Record. "I've had a few people say they aren't keen on the health record because it means the government can pry into your information. The government and the banks and a whole lot of other institutions already have a lot of your private information. Medicare records have a lot of health information on them," he says.

"I tell everyone who comes to our community activities to sign up for My Health Record. At least with electronic health you are sharing information for a really important reason – to look after your own healthcare."

A REALLY IMPORTANT ISSUE IN THE ROLL OUT OF MY HEALTH RECORD WILL BE MANAGING THE WORKLOAD FOR NURSES AND MIDWIVES...



CALL FOR DEADLY WORM TO BE A NOTIFIABLE DISEASE

Researchers have called for a public response to a life threatening parasitic worm that could be quietly infecting up to 60% of vulnerable Australians in remote northern communities.

Strongyloidiasis is an infection caused by parasitic worms which crawl in through human skin and reproduce inside stomachs and digestive organs indefinitely.

The parasite which infects an estimated 370 million people worldwide is more common than malaria, but is the most neglected of the tropical diseases, Flinders University researcher Dr Kirsten Ross said.

"Strongyloidiasis is generally considered a disease in developing countries but we actually see it infect disadvantaged populations right here in Australia. It's impacting Indigenous communities, refugees, and even returning holidaymakers."

Detection rates are low despite potentially high infection rates particularly in Indigenous communities living in tropical climates, Dr Ross said.

"The worm tends to be seen in areas where septic or sewerage systems are not working very well or properly at all.

"Despite the worm's prevalence in up to 80% of Indigenous communities, the number could actually be higher because it remains difficult to detect. There is also no centralised record of cases to track progress."

Symptoms include diarrhoea, coughing and a hives like rash. There have been confirmed examples of fatal cases in Australia.

Researchers have called for strongyloidiasis to be added to the Australian National Notifiable Disease List.

"The problem is we don't always look for it and so people can be completely unaware. We also don't know what environmental conditions allow for its survival," Dr Ross said.

POST-TRAUMATIC STRESS DISORDER TRIAL FOR VETS

Participants are being recruited for an Australian-first research program to improve the treatment of post-traumatic stress disorder (PTSD).

The Rapid Exposure Supporting Trauma Recovery (RESTORE) trial is working with past and present Australian Defence Force (ADF) personnel to help develop an effective treatment for PTSD.

The trial will assess whether an intensive form of prolonged exposure therapy of 10 sessions over two weeks is as effective as the standard 10-week treatment currently offered.

Statistics show about 8.3% of ADF members have experienced PTSD in the past year, compared to the national average of 5.2%.

Chief Investigator at the University of Melbourne Centre for Post-traumatic Mental Health David Forbes said PTSD was the most prevalent mental health disorder among Defence personnel.

"We need to develop and test new and innovative approaches to help those not benefiting from current approaches. The outcomes of this trial will help not just the military and veteran community but also other Australians with PTSD as we improve PTSD treatments for everyone."

The trial is recruiting veterans and current serving members of the ADF aged 18-75 years. Participants must be experiencing PTSD symptoms related to a traumatic experience that occurred during military service. phoenixaustralia.org/RESTORE

SITTING DOWN A RISK FOR FRAILTY

Women who spend more time sitting down as they get older are at higher risk of becoming frail, Queensland researchers have found.

The University of Queensland (UQ) study used data from the Australian Longitudinal Study of Women's Health to assess the sitting patterns of almost 5,500 middle-aged Australian women over a 12-year period.

Women who had high levels of sitting, about 10 hours a day were more at risk of becoming frail, according to the research published in *American Journal of Epidemiology*.

"We classed 5.5 hours sitting per day as a medium level of sitting, while 3.5 hours per day represented a low level," NHMRC Research Fellow Dr Paul Gardiner from UQ's Centre for Health Sciences Research said.

"Those with consistently less sitting time had a lower risk of developing problems."

Women were more at risk than men, Dr Gardiner said.

"Frailty means that you have fewer resources to recover from illness or injury. It's also linked to increased risk of hospitalisation, falls, moving into residential care facilities and premature mortality."

The effects of sitting too long could be reversed, the researchers found. "Participants who decreased their sitting time by approximately two hours per day reduced their risk of vulnerability," Dr Gardiner said. "In order to remove the increased risk altogether, women should try and limit their sitting time to low or medium levels, as well as being physically active."





WORKPLACE CULTURE

By Gay Taylor

Much has been written about the importance of positive organisational culture in health workplaces, but surely the real test of cultural safety lies in tangible, measurable patient outcomes; evidence that can sometimes be elusive.

So what is workplace culture, and why does it matter to nurses, and more importantly to patients?

The notion of culture as applied to organisations became popularised in the 1980s, and over the next two decades, healthcare settings were being encouraged to focus on financial accountability by assuming a business model culture (Davies et al.). During the late 1990s and beyond, successive governments both here and in the UK shifted the emphasis onto a culture of quality, but with pro-market policies continuing to drive health reforms, it is possible that this culture change was superficial at best, despite the motivational rhetoric (Jacobs et al. 2013).

In studying organisational culture, researchers have proposed that workplace culture could be divided into two basic concepts:

- Something that an organisation intrinsically 'is', characteristics of the organisation that are fairly fixed, and are unlikely to change.
- Culture as something that an organisation 'has'; that is, a group of cultural attributes that can be changed in some way to produce different outcomes (Kaufmann & Mc Caughan, 2013).

This second concept of workplace culture encompasses the attitudes, values, ritual and behaviours that are the accepted 'way things are done around here' (Davies et al. 2000, p.112), and which are passed on to new recruits. The impact of an unhealthy culture was clearly demonstrated by the Independent Inquiry into Care at the Mid Staffordshire NHS conducted over four years, in response to higher than normal mortality rates and patient complaints. The Inquiry

found that the organisation had a prevailing culture of management bullying and a lack of transparency in communicating with both staff and patients. Added to this was chronic understaffing due to job cuts leading to very low staff morale and compounding absenteeism. This top-down culture of blame and the poor standard of communication, particularly in the Emergency Department meant that serious deficiencies in standards of care had become a chronic problem for the organisation (Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013).

In contrast to this, a study undertaken by Pennsylvania State University in 2005 found that tangible improvements to patient outcomes could be linked to empowering management practices that fostered staff retention and minimised turnover in a range of nursing homes. (Barry, Brannon & Mor, 2005). Using Kanter's (1977) theory of structural power in organisations as a guiding principle, the investigators posited that workers who feel a sense of control over their working conditions would be more likely to want to stay with the organisation, thus providing greater stability for the residents at the nursing home. In studying 307 nursing homes, two staff-empowerment strategies were considered:

- Allowing greater autonomy and decision-making capacity amongst nursing/care staff in relation to resident care. (Power structures)
- Providing greater opportunities for career advancement by proving rewards, training or encouraging participation in committees relating to resident care. (Opportunity structures)

They hypothesised that nursing homes using such empowerment strategies would likely experience better aggregate resident outcomes, specifically in social engagement scores, and in the incidence of pressure ulcers. In both instances, staff retention was found to have a positive effect on social engagement and a lower incidence of pressure ulcers. The discussion around these results explained that in facilities with high staff turnover, nurses and carers felt that continually inducting new staff was the same as working 'short-staffed'. Interestingly, facilities that had a high turnover of staff, but retained a core of experienced staff scored more highly in resident social engagement than those with low turnover and high retention of staff. One explanation offered for this was that whilst facilities with high retention/low turnover were able to provide better physical care as evidenced by the pressure ulcer scores, the 'mechanisation' of experienced staff might have a negative impact on social engagement. Another curious finding was that the power structures (greater autonomy) had the most impact on social engagement scores, whilst the opportunity structures (rewards/training) affected the incidence of pressure ulcers.

The implications for nurse managers from this study are quite exciting, and offer opportunities for staff development that are not solely dependent on the unpredictability of government budgets. Very few nurses and carers are 'in it for the money', and it is pleasing to see that providing opportunities for them to be involved in patient decisions and to advance their careers not only empowers these workers, but promotes higher quality care outcomes.



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Gay Taylor is a registered nurse and coordinator at Community Home Care, Margaret River WA. Her professional interest is in enhancing workplace communication and improving the culture in healthcare workplaces.



NICK BLAKE AT THE INTERNATIONAL LABOUR ORGANISATION MISSION TO PAPUA NEW GUINEA

THANK YOU NICK

By Andrew McCarthy, Debbie Richards and Anna Amatangelo,
Federal Industrial team

In June we said goodbye to retiring Senior Industrial Officer Nick Blake who worked at the ANMF Federal Office for over 22 years.

There is much we will miss about Nick, not only as a much loved friend and colleague, but also his commitment, skilled advocacy and leadership representing the industrial interests of nurses, midwives and carers, whether it was before industrial tribunals, representations to government and other bodies, enterprise agreement negotiations or advice to ANMF branches and members.

Nick's expert advice and guidance on all matters industrial, contributed enormously to the building of a strong national union providing a united voice for ANMF members and the nursing, midwifery and caring professions overall.

His work in the federal office was broad ranging covering workforce, legal and industrial matters representing the ANMF at both a national and international level.

Nick leaves with a proud record of achievement and while it is impossible to do justice to his 22 years as the senior industrial officer, we hope to convey some of the significance of his work through the following examples.

Nick's time with the ANMF coincided with a period of momentous change in federal industrial relations laws beginning with the Workplace Relations Act 1996 and ending with the current Fair Work Act 2009. In between was the Howard government's WorkChoices legislation with its extreme anti-worker agenda.

With each round of legislative change, the award system (setting minimum standards for wages and conditions) came under attack threatening many years of work developing common national industry rates of pay and conditions for nurses and midwives. This

work established that nurses and midwives should be remunerated in accordance with their levels of responsibility, education and experience rather than based on the particular work setting or sector in which they are employed.

Nursing classifications, career structures and incremental advancement were, and continue to be, integral to maintaining proper national standards for nurses and midwives.

Despite years of attacks on these and other award entitlements, Nick's expert guidance, negotiation and advocacy skills ensured key standards for nurses, midwives and carers were maintained and improved. He was also instrumental in achieving the making of the modern Nurses Award in the face of alternative proposals to split nursing pay and conditions across different sectors.

His work has also contributed to improvements in the wages and conditions of nurses through the development and implementation of federal industrial strategies for enterprise bargaining including input into various ANMF national and branch campaigns in the public, private and aged care sectors. Improvements in nursing wages and conditions have included the implementation of workload and staffing mechanisms such as nurse/patient ratios, professional development leave provisions and post graduate qualification allowances.

As one Branch industrial officer said recently, Nick has always been in the background providing advice and assistance in all that we do.

Nick worked with the Victorian Branch to secure significant wage increases for nurses working in the aged care sector and subsequently achieved similar results

in a case for aged care nurses in the Northern Territory. In more recent times in collaboration with the ANMF Tasmanian Branch he won significant improvements for public sector community health nurses in Tasmania, resulting in new classifications and wage increases.

Nick had a long involvement in representing the interests of the ANMF regarding nursing workforce issues particularly those concerning permanent and temporary skilled migration. He worked with the ACTU and other unions to stop the exploitation and unfair treatment of nurses coming to Australia on temporary work visas, advocating that temporary visa workers receive the same wages and conditions as local nurses in the same workplace. Eventually adopted by the Labor government in 2008, this protection remains in place today.

While this overview is, at best, just a sample of Nick's work with the ANMF, we hope it provides some insight into his contribution and commitment to the ANMF and the broader union movement.

This message from Emily Shepherd, ANMF Tasmanian Branch Secretary sums up Nick's personal and professional approach to his work:

"The Tasmanian Branch has had a close working relationship with Nick and his support has always been unwavering. Smaller branches are often dependent on federal resources, but Nick went above and beyond to assist the Branch with his expert industrial advice in workload disputes, rule changes and numerous other disputes particularly related to bargaining and the implementation of new Agreements with the State government. His calm, practical advice was always well received and the Tasmanian Branch Secretary, Branch Council and staff would like to thank Nick for his incredible support over many years and wish him all the best in his retirement."

On behalf of us all at Federal Office we say thank you to Nick and send him our very best wishes for the future.

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WORKING LIFE: JESS DAVIS

By Natalie Dragon

Going to Africa was a childhood dream for Jess Davis. One that came true recently after she spent two months on board the Africa Mercy while it was docked in the Central African nation of Cameroon in late March.

"I always wanted to go to Africa. I always thought I would go help and leave, but it was so much more than that. I wasn't aware of the profound effect it would have on me."

Jess joined more than 400 volunteers on the world's largest independent hospital ship. She first heard of Mercy Ships after a friend volunteered in Madagascar for two weeks as a theatre nurse. It was put on the backburner until she saw a TV documentary about the international Christian medical charity that operates the Africa Mercy which inspired her to volunteer.

"Everyone that was there was there for the same reason, they wanted to be there and it made it really special. I felt like I really belonged, making an impact on people's lives with like-minded people."

"I never expected it to affect me so personally - how I have grown and the impact it has had. I made so many friendships on the ship. Friendships I haven't ever had in Australia. For the time you are there, you are the pure, authentic version of yourself in an environment that, while highly emotional, it wasn't stressful. You just build relationships that are so real. I have come to love these people like they are family. It was incredible and I did not expect that at all."

The Africa Mercy docked in the port city of Douala, Cameroon, in August 2017 and provided almost 4,000 life-changing surgeries on board. More than 8,000 were treated at a land-based dental clinic and healthcare training was provided to local medical professionals during its 10 months in port.

Jess said her faith was pivotal to her in not being shocked by what she saw.

"The hardest thing I think was to prepare my heart for what I was going to witness. As I had not ever experienced anything like this before, I wasn't sure how I was going to react in certain situations, how I was going to feel, or how I was going to cope."

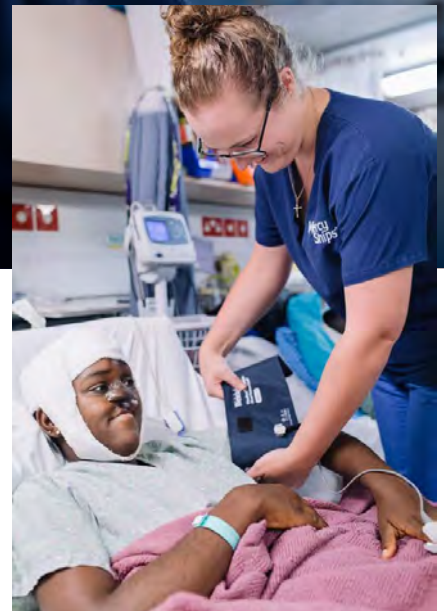
"Women were having open hysterectomies. These women had uteruses the size of footballs sometimes, and come back with wounds up to 20cm. Post-operatively, they were just having Panadol for pain relief. You have to be open-minded in what you are going to experience and know that it is going to be different."

Back at home, Jess works on a colorectal and general surgical ward at the Mater Private Hospital, in Brisbane. She had four years' nursing experience before she volunteered. Mercy Ships requires two years' experience, preferably in theatre, surgical or high dependency areas.

"At home, it's completely different from the work I did in Africa, but in a sense it is the same; nursing is nursing. My work at home has given me the skills to be able to nurse effectively using subtle cues of the patient without language. I cannot speak French, or one of the 250 local Cameroonian languages. While it was a challenge, international sign language became a great friend when the local translators were completing other tasks."

Jess says she learnt that African values of family and relationships were integral to health and healing.

"I did not completely understand that at first. On the ship, men, women and children were playing board games with each other or soccer in the corridor. They would tell you



they were in pain or hungry and then go play. You would go back to them and they would have settled just from being with their family."

Jess decided to go back and serve again before her first fortnight on board was up. She is going back for eight weeks next month. Volunteers are self-funded, and pay for their own flights, vaccinations and food. "I would literally sell everything to go and have this experience. In my personal opinion everyone should do this."

"All nurses should be given this opportunity to go into a developing country and see things we do not see here in Australia. It put a lot of things into perspective for me: how lucky I am to be white, born in Australia, that I have had an education and have access to free healthcare and can afford private healthcare."

To read Jess' blog, visit:
jessmercymission-blog.wordpress.com

Jess' fundraising page is at:
mercyships.org.au/giving/jess-goes-guinea/

GLOBAL

DRUG COULD SAVE THOUSANDS OF WOMEN'S LIVES

A new formulation of a drug to prevent excessive bleeding following childbirth could save thousands of women's lives in low and lower-middle-income countries, according to a new study.

Currently, oxytocin is the first-choice drug for preventing excessive bleeding after childbirth but it must be stored and transported at 2-8 degrees Celsius, making it difficult in many countries and depriving many women access to the lifesaving drug.

Led by the World Health Organization (WHO) with MSD for Mothers and Ferring Pharmaceuticals, the study found an alternative drug – heat stable carbetocin – as safe and effective as oxytocin in preventing postpartum haemorrhage yet without requiring refrigeration and retaining efficacy for at least three years when stored at 30 degrees Celsius and 75% relative humidity.

About 70,000 women die each year due to postpartum haemorrhage, which increases the risk their babies will also die within one month.



The clinical trial, the largest of its kind, studied almost 30,000 women who gave birth vaginally across 10 countries – Argentina, Egypt, India, Kenya, Nigeria, Singapore, South Africa, Thailand, Uganda and the UK.

Each woman was randomly given a single injection of either heat-stable carbetocin or oxytocin immediately following the birth of her baby, with the study finding both drugs equally effective at preventing excessive bleeding.

"The development of a drug to prevent postpartum haemorrhage that continues to remain effective in hot and humid conditions is very good news for the millions of women who give birth in parts of the world without access to reliable refrigeration," Dr Metin Gulmezoglu said, from the Department of Reproductive Health and Research at WHO.

The next phase will involve a regulatory review and approval by countries.

GLOBAL

ICN SUPPORTS EARLY CHILDHOOD DEVELOPMENT IMPROVEMENT

The International Council of Nurses (ICN) has signed a Memorandum of Understanding with the Childhood and Early Parenting Principles (CEPPs) Global Initiative to help actively promote a multi-sector approach to Early Childhood Development by organisations and governments at all levels.

As part of the Global Initiative, ICN will collect and expand the knowledge base of scientific evidence and best practice in maternal and perinatal health and early childhood development.

It will then share the knowledge between countries globally and join forces with other health professionals, educational institutions and organisations involved in the field to lobby policymakers at the highest level and raise awareness about the importance of supporting maternal health and early childhood development.

The ultimate aim is to provide capacity for professional education and a continuum of care for mothers and infants during the critical period.

The CEPPs outlines seven principles geared towards building partnerships between government, the private sector, civil society and professional organisations.

"Nursing practices and knowledge contribute greatly to development in early childhood," ICN Interim CEO Professor Thomas Kearns said.

"From pre-natal care, maternal education, improving access to care, education, health promotion and disease prevention, nurses are a critical part of maternal and childhood health and early childhood development."

ENGLAND

NHS LAUNCHES RECRUITMENT DRIVE

The National Health Service (NHS) has launched the biggest recruitment drive in its history in a bid to tackle staffing shortages and attract thousands of new nurses to the profession.

Triggered by mounting staff shortages, the comprehensive TV, radio and social media campaign is aiming to attract new nurses by highlighting the vast range of opportunities available in key areas including mental health, learning disability and community, and general practice nursing.

The NHS is facing a critical staff shortage with 34,000 nursing posts currently vacant and unfilled.

The campaign is aiming to increase the total number of applications to the NHS by 22,000, as well as double the number of nurses returning to practice and improving retention of staff across all sectors.

The Royal College of Nursing (RCN) is hopeful the new campaign can help break the cycle of rising staff shortages crippling the NHS.

"This powerful campaign marks a turning point but the focus on the next generation needs to continue long after the birthday candles have gone out," RCN Chief Executive and General Secretary Janet Davies said, referring to the NHS celebrating its 70th year of operation.

"Nursing is a job like no other and the difference you make to people's lives is very visible and highly rewarding. Patients get the majority of care from nurses and the next generation will be at the forefront of innovation."

VACCINATION DURING PREGNANCY: THE FIRST DOSE FOR NEWBORNS

By Mark McMillan RN

Midwives are integral to the provision of high quality care of pregnant women. Vaccination during pregnancy is a relatively new core practice in the provision of quality pregnancy care in Australia.

Understanding the evidence and recommendations for vaccination during pregnancy equips midwives and nurses with the knowledge to engage with women and their families on the topic of vaccination. Midwives and nurses are also instrumental for the provision and administration of pertussis and influenza vaccines during pregnancy.

Antenatal vaccination is the most effective method available to reduce the risk of influenza or pertussis (whooping cough) in newborns and infants less than six months of age.

Immunisation during pregnancy can deliver protective antibodies transplacentally to the fetus and confer protection in infants too young to be immunised. It also has the dual benefit of protecting pregnant women and reducing the risk of transmission of infection from mother to infant.

In the May 2018 Federal Budget it was announced that the diphtheria, tetanus, and pertussis-containing vaccine (dTpa) will be added to the National Immunisation Program (NIP) for pregnant women. This replaces state government funded programs. Influenza vaccines for pregnant women have been available on the NIP since 2010. This means that pregnant women do not need to pay for the cost of influenza and pertussis vaccines.

Infections during the first six months of life

Infants are vulnerable to severe disease due to their immature immune system. Until they are able to produce an effective antibody response to their primary immunisations they remain at increased risk of vaccine preventable diseases. This means that they are vulnerable to pertussis infection until four to six months of age, and even later for influenza. Antenatal vaccination is the best method available to reduce this risk in their first six months of life. The "Cocooning Strategy" that involves vaccinating close contacts of infants is costly, difficult to implement, and not necessarily effective at protecting infants (Blain et al. 2016).

Burden of pertussis and influenza in Australian infants

In 2017, the highest number of influenza cases were reported since the 2009 pandemic year (Department of Health, 2017). Surveillance from 11 sentinel hospitals in

Australia during the 2017 season identified 154 infants aged less than six months who were admitted to hospital with influenza, and 21% of these required an intensive care admission (McRae J et al. 2018).

Despite sustained high vaccine coverage in children under five years of age, Australia is experiencing a resurgence of pertussis, including in young infants less than six months of age (Marshall et al. 2016).

Between 2006 and 2012 the rate of hospitalisation in Australian infants less than six months of age was 1832 cases per 100,000 population, with 10 deaths in unvaccinated infants less than two months of age (Pillsbury et al. 2014).

Vaccine effectiveness for infants

Infants of pregnant women vaccinated during pregnancy have been shown to have reduced rates of influenza, and influenza related hospitalisation, during their first six months of life (McMillan et al. 2014).

However, the effectiveness of the influenza vaccine is dependent on how well it matches the circulating influenza strain each influenza season.

A population wide antenatal pertussis immunisation campaign in the UK has demonstrated that the pertussis vaccine is effective at reducing pertussis cases in infants less than two months of age (Amirthalingam et al. 2014).

In Australia, antenatal pertussis vaccination has also demonstrated that it is effective in reducing hospitalisation from pertussis in infants less than six months old (Quinn et al. 2018).

Vaccine safety

Over 100,000 pregnant women have now been included in studies investigating adverse events following influenza vaccination. From these studies there is no evidence of an association between having an influenza vaccine during pregnancy and adverse outcomes for pregnant women, or the fetus (Giles et al. 2018, McMillan, 2014).

Evidence also suggests that pertussis immunisation during pregnancy is not associated with harm for the fetus or neonate. Medically attended events in pregnant women are similar between pregnant women vaccinated with a pertussis







vaccine and unvaccinated groups (McMillan et al. 2017).

Routine antenatal vaccine recommendations

The Australian Technical Advisory Group on Immunisation (ATAGI) recommends the following for pregnant women: (ATAGI, 2017)

- Influenza vaccine – for all pregnant women at any stage of pregnancy, particularly those who will be in the second or third trimester during the influenza season.
- Diphtheria, tetanus, and pertussis-containing vaccines (dTpa) – as a single dose during the third trimester of each pregnancy (ideally at 28–32 weeks).

Vaccine delivery during pregnancy

Despite current recommendations, vaccination rates during pregnancy are sub-optimal. Midwives, obstetricians, and shared care physicians generally support immunisation of pregnant women (Schrage et al. 2003). The hurdle is embedding immunisation into pregnancy care. A recommendation from a provider and receipt of the vaccine at the point of pregnancy care are two of the most effective ways to increase antenatal vaccine uptake (Mohammed et al. 2018). Midwives and nurses that work in clinics that provide care for pregnant women should consider taking the following steps:

- ensure the availability of NIP

KEY POINTS



Infants are unable to produce an effective antibody response to pertussis vaccines until 4–6 months of age, and even later for influenza.



Newborns and infants are most susceptible to severe illness from pertussis and influenza during their first six months of life.



Vaccination of pregnant women is the most effective method to reduce the risk of pertussis and influenza in their child, especially during their first two months of life.



Large population studies have not found a clinically significant association between having influenza or pertussis vaccine during pregnancy and adverse outcomes for pregnant women or fetus.



Engaging with pregnant women and offering the influenza vaccine at any stage of pregnancy, and the dTpa vaccine at 28 to 32 weeks gestation, will help protect children too young to be immunised.

pertussis and influenza vaccines at the point of pregnancy care;

- have the ability to maintain cold chain of vaccines on site;
- organise standing medication orders for pertussis and influenza vaccines; and
- complete an approved training course to administer vaccines.

Mark McMillan RN, M Clin Sc, GDipHealthProm, GCEpi. is at the Vaccinology and Immunology Research Trials Unit at the Women's and Children's Hospital, Adelaide.



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Dr Micah D J Peters

NURSING RESEARCH: FROM INTEGRATION WITH CLINICAL PRACTICE TO FUTURE SCIENCE

Nurses and midwives are integral to the conduct of many research, implementation, and evaluation studies across healthcare. At the core of this research is the observation and collection of data, which in turn underpins evidence-based practice as well as the evaluation of the effectiveness of the care provided by nurses and midwives across all areas of the healthcare system.

Nurses and midwives need to have efficient and ready access to the right information at the right time to make evidence-based decisions for patient care and planning. Clinical audits can be one way that nursing and midwifery professionals can efficiently adopt simple data collection and utilisation practices for rapid patient and health service impact (Cadeddu et al. 2017; Yorston and Wormald, 2010).

One practical example is where nurses in China led an implementation study to improve how cancer therapy induced skin toxicities were managed in their unit, resulting in fewer and less severe toxicities in only a few months (Guo et al. 2017). Nurses and midwives can however face challenges integrating research into their often busy and varied roles (Evans et al. 2014).

While the provision of direct patient care will always be the cornerstone of nursing, as new technologies are integrated into the healthcare system, the way nurses are educated, care for patients, and engage with research will evolve (Risling, 2017; Westra et al. 2017). Various technological advancements have changed the way that patient data is collected and used. Many clinical sites are now adopting electronic patient records that can collect and convey significant amounts of information to clinicians.

Rollout can however encounter mixed reception from clinicians who then need to adapt their practice to incorporate new computerised systems (de Veer and Franke, 2010). Technological developments are certainly difficult to seamlessly integrate into busy routine practice but can offer opportunities for benefit and greater efficiency.

'Big data' is a recent term that refers to newly emerging evidence sources consisting of enormous datasets that until recently were far too large, diverse, and complicated for readily available, and accessible computer systems to handle. In healthcare, big data is

generated through electronic health records, personal portable or wearable devices (eg. smartphones and fitness bracelets), patient or disease registries, tumour banks and other sources. The use of these large datasets has the capacity to rapidly advance healthcare including personalised medicine, patient safety through risk and predictive assessment, and health service efficiency and effectiveness (Brennan and Bakken, 2015). Understanding how to use big data will become a vital part of the education of future nursing and midwifery professionals (Topaz and Pruinelli, 2017).

As nurses, midwives, and researchers become more confident and skilled with using new technologies including big data in their everyday working lives, there are great opportunities for patient outcomes and the way care is delivered to be rapidly and significantly improved. To return to a cancer treatment toxicity example, advances are being made to use big data to effectively predict which patients are likely to be affected adversely by cancer therapies before treatment has even begun (Meldolesi et al. 2016).

Nursing and midwifery research has an exciting future alongside and integrated with technological advancements in how data is collected, analysed, and used.

Nurses and midwives have an important role to play with the advent of big data, and will be integral to current and future research that seeks to collect, link, make sense of, and most importantly put the lessons from big data to work in clinical practice where it can make a difference to patients' lives, care, and the way healthcare professionals work (Pickler, 2018).

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INFECTION CONTROL

Infection control is a crucial component for the implementation of best practice for nurses and midwives in order to ensure patient/resident safety as well as to provide high quality care.

It is imperative we remain competent in this area at all times, however in the winter months, with colds and flu affecting so many, it is vital we remain diligent in this practice and encourage others to do the same in order to prevent further spread of these microbes.

This is an excerpt from the ANMF's Infection Control and Prevention tutorial on the Continuing Professional Education (CPE) website. The tutorial is FREE for QNMU, NSWNMA and all ANMF members across Australia.

WHAT IS INFECTION CONTROL?

Infection control refers to policies and procedures used to minimise the risk of spreading infections, especially in hospitals and healthcare facilities.

These policies and procedures relate to disease surveillance, investigation, prevention and control of the spread of infections and their causative microorganisms.

Ensuring the use of safe, effective and ethical infection prevention and control measures is an important component of nursing and midwifery care.

Knowledge of clinical infection control practices is continually expanding. While the principles of infection control (ie. prevention, transmission and control) do not change, specific clinical practices evolve as a result of new evidence.

All nurses and midwives, in all roles and settings, can demonstrate leadership in infection prevention and control by using

their knowledge, skill and judgment to initiate appropriate and immediate infection control procedures.

Infection control is a critical concern for clients, healthcare workers, facility administrators and government agencies. Infection control measures are designed to combat everything from the spread of colds and flu to hepatitis B and C, SARS, HIV/AIDS and other potentially life threatening diseases.

Appropriate infection control measures may range from something as simple as following correct hand washing procedure to coordinated policies involving employee health screening, immunisation and treatment.

All these measures should be incorporated into synchronised, organisation-wide infection control programs at healthcare facilities of all sizes and types.

Healthcare personnel are a broad group. These may include paid and unpaid persons working in healthcare settings who have an impact on infection control.

Visitors are also a potential source of infection and may also be vulnerable to infections present in the healthcare setting.

WHAT IS AN INFECTION?

Infection is the process of microbial invasion of the body.

A microbial disease is often called an infective disease.

Infective diseases that are readily communicable from person to person are called infectious or contagious.

Colonisation is the presence and multiplication of a microorganism without tissue invasion or damage. A patient with microorganism colonisation does not show signs of infection and is not readily recognised as a reservoir of an infectious agent.

Microorganisms are forms of animals and plants too small to be seen without the aid of a microscope. They are found in their millions in every situation where it is possible for life to exist.

They are present:

- in the air, water and soil;
- in dust;
- in and on food;
- on every surface; and
- in and on the bodies of other organisms, including humans.

Microorganisms may be **pathogenic** or **non-pathogenic**.

Only a small proportion of microorganisms occurring in nature are **pathogenic** – ie. capable of causing disease.

Most pathogenic microorganisms are free-living in soil, water etc. and are unable to invade the human body. However, when they are able to overcome the body's defences they are called **true pathogens**.

Non-pathogenic microorganisms do not cause disease under normal circumstances and when they are in their normal environment. They become pathogenic when transferred to a different environment.

Opportunistic pathogens are normal flora

which under certain circumstances (eg. when the body defences are impaired), may invade the tissues and cause disease.

Commensal microorganisms are also called **normal flora** because they live in or on the body without causing disease and are also beneficial.

Normal flora performs a number of useful functions when they remain in their normal location, that is, on the skin, the mucous membranes of the upper respiratory tract, intestines and vagina.

The spread of infection requires an infectious agent – a pathogen that has the potential to cause infection which may be viral, bacterial, fungal or parasitic.

The infectious agent needs a reservoir where it can live, grow and reproduce. Reservoirs are warm, moist places. Humans, animals or the inanimate environment (eg. water, food, soil and soiled medical equipment) are potential reservoirs.

Human reservoirs include individuals with an acute infectious disease, those who are in the incubation period of the disease and asymptomatic carriers.

The transmission of infection also requires a susceptible host.

Susceptibility to an infectious agent varies depending on age, general physical, mental and emotional health, the amount and duration of exposure to the agent, and the immune status of the individual.

Chronic disease, shock, coma, traumatic injury, surgical procedures or treatment with irradiation or immunosuppressive agents increase a person's susceptibility to infection.

How the infectious agent is transmitted from the reservoir to the susceptible host is called the mode of transmission.

Transmission requires a route for the infectious agent to exit the reservoir (a portal of exit), a mode of travel to the susceptible host (a mode of transmission) and a route to enter the susceptible host (portal of entry).

An infectious agent can exit the reservoir and enter the host through various body systems eg. respiratory, gastrointestinal, genitourinary tracts, skin lesions and through mucous membranes.

HUMAN DEFENCE MECHANISMS

Some human defence mechanisms prevent the entry of microorganisms and others destroy microorganisms that gain entry to tissues.

There are three lines of defence.

1. Mechanical barriers eg. skin, mucous membranes;
2. inflammatory response; and
3. immunity

Mechanical barriers

- The skin forms an intact, waterproof barrier against microorganisms and its sweat and sebum are bactericidal to some organisms.
- Mucous membranes trap organisms until they can be removed eg. by washing out of the body via tears or saliva, or by coughing or sneezing.

- Body excretions such as saliva, tears, gastric juice and bile are anti-bacterial.
- Normal flora protect the body by suppressing invasions by pathogenic microorganisms.
- Lymphoid tissue, which is found in many areas of the body, filters microorganisms from the circulation and destroys them.

Inflammatory response

Once microorganisms have gained entry to the tissues, they will start to multiply and release substances, which stimulate inflammatory processes.

The damaged tissue cells also release substances, which increase blood flow through the tissue by inducing dilation of blood vessels leading to redness and increased temperature in the area.

The inflammatory response causes large numbers of polymorphonuclear leucocytes and antibacterial substances to concentrate at the site of infection.

Polymorphonuclear leucocytes are macrophages ie. able to engulf and ingest microorganisms by a process called phagocytosis.

Phagocytosis usually results in death of the microorganisms and cells of the host, leading to the formation of pus.

If microorganisms survive these defence mechanisms, their multiplication may lead to local abscess formation and perhaps the spread of infection to other parts of the body.

Immunity

Immunity is a state of having sufficient biological defences to avoid infection, disease, or other unwanted biological invasion.

The immune response is initiated during the inflammatory response and involves a group of cells called lymphocytes.

Lymphocytes are found in the blood but are also abundant in lymphoid tissue ie. spleen, lymph nodes, tonsils, bone marrow and the thymus gland.

When macrophages engulf and ingest microorganisms they transfer antigens to their own surface. This is a foreign substance, usually a protein that stimulates the formation of immunoglobulin's antibodies, which are protective.

Lymphocytes circulate in the blood and are programmed to recognise the antigen on the surface of leucocytes.

Once recognised, the T-Lymphocytes bind to the leucocytes and are activated as 'helper T-lymphocytes'. These then multiply and travel to the lymph nodes and/or spleen

THERE ARE FIVE MODES OF TRANSMISSION:

1. Contact transmission

Direct contact transmission involves contact between the infectious agent and the susceptible host.

Indirect contact transmission involves contact between a susceptible host and a contaminated intermediate object such as a needle, instrument or other equipment including hands of healthcare workers.

2. Droplet transmission

Involves contact with the conjunctivae or mucous membranes of the nose or mouth (of a susceptible host) by large particle droplets that contain the infectious agent.

Droplets are released through talking, coughing or sneezing and during procedures such as suctioning and bronchoscopy.

Bacteria and viruses can live outside of the body for some time, dependent on the nature of the microorganism and the environment ie. hot, cold, damp, sunny.

Some viruses can survive on indoor surfaces for up to seven days. Some last on hands for only an hour- think about all the surfaces you can potentially touch in an hour!

Some last much longer, such as the *Clostridium difficile* (C. difficile) which can survive for up to five months.

Flu virus can survive as droplets in the air for several hours, low temperatures increase their survival in the air, they can survive for up to 10 hours on hard surfaces and up to four hours on soft surfaces.

3. Vehicle transmission

Food, fluids or medication contaminated with an infectious agent can act as a vehicle for transmission when ingested.

Contaminated instruments/equipment can also act as a vehicle for transmission.

4. Airborne transmission

Small particle residue of evaporated droplets or dust particles remain suspended in air for long periods and may contain infectious agents.

Infectious agents carried in this manner can be widely dispersed by air currents and can be inhaled, or deposited on to a susceptible host in the same room or over a longer distance.

5. Vectorborne transmission

Vectors such as insects may harbour an infectious agent and transfer it to humans through bites or stings.

Mosquitoes, fleas, lice and ticks move from host to host and may infect large numbers eg. mosquitoes can carry the malaria parasite or West Nile virus, and deer ticks may carry the bacterium that causes Lyme disease.



where they stimulate production of other protective cells and chemicals, these being Killer T-cells and B-lymphocytes.

Killer T-cells are produced which recognise and destroy invading microorganisms.

B-lymphocytes (antibodies) are produced which bind their immunoglobulin's to the antigens.

Immunoglobulin's are specific – they react only with the antigen that stimulates their formation. Therefore immunity to one disease does not lead to immunity for different diseases.

Infected body cells are destroyed and ingested by the macrophages thus removing them from the site of infection.

THE RESULT OF THE IMMUNE RESPONSE IS THAT TWO FORMS OF IMMUNITY DEVELOP:

1. Antibody-mediated (humoral) immunity
2. Cell-mediated (cellular) immunity

Both the T and B-lymphocytes can become 'memory cells' that retain a memory of the original foreign substance (antigen) that stimulated their formation.

Memory cells respond to subsequent contact with the specific antigen and reactivate the immune response.

It is largely B-cells that become reactivated against bacterial invasion also known as humoral immunity, while T-cells respond to viral invasion and stimulate cellular immunity.

Immunity may be **innate** (inborn) or may be **acquired**.

Immunisation is a process by which resistance to an infectious disease is **induced artificially**.

Innate Immunity

Innate immunity is the first line of defence in our immune system. It is non-specific and responds to the common features on all pathogens. It is absolutely essential for survival as it creates barriers to microbial invasion and provides critical biochemical and cellular first responders to infections.

Innate immunity includes physical barriers, like our skin and saliva, as well as innate immune cells like macrophages, mast cells, neutrophils, and basophils.

They are up and running in our body constantly to protect us when an infection is first encountered.

Factors influencing innate immunity include:

- Hereditary
- Age
- Nutritional status
- Hormonal influences
- Intact skin and mucous membrane
- Phagocytosis – the body's ability to protect itself.

Acquired Immunity

Is not present at birth but is developed throughout life and may be **passively** or **actively** acquired.

Passive Immunity

Is the transfer of products of an immune response to an individual without any involvement by that individual's tissues and is a **temporary** response.

Immunoglobulin's may be passively conferred in one of three ways.

- In utero immunoglobulin's from the mother are transferred across the placenta to the foetal bloodstream.
- After birth in breast milk.
- Serum (antiserum) prepared from pooled blood plasma contains antibodies and may be injected directly into patients e.g. tetanus immunoglobulin may be injected to prevent tetanus and may be used in the management of a tetanus prone wound.

Active Immunity

Is acquired as a result of the stimulation of an individual's immune system.

Active immunity is more permanent, providing protection for years or in some instances, for life.

Active immunity may be acquired by:

- An attack of an infectious disease. The degree of immunity varies and in some instances is high eg. measles and mumps where a second attack of the disease is rare. In other cases, the degree of immunity is low and repeated attacks of the disease can be expected eg. the common cold.
- Repeated sub-clinical attacks of the disease. When a specific disease is common in a community, pathogenic microorganisms may invade the tissues of individuals repeatedly, but there may be no recognisable manifestations of the disease – or there may be only signs and symptoms of a mild attack. The body produces immunoglobulin's each time it is invaded, so the individual acquires immunity against a full clinical attack of the disease eg. Natural immunity to *Haemophilus influenzae* type b (Hib) is based primarily on antibodies that are thought to develop in response to subclinical infections.

Vaccination

- Vaccines induce a specific active artificial immunity to microorganisms.
- Vaccines are suspensions of either live, dead or weakened organisms which are introduced into the body to stimulate the production of specific immunoglobulin's.
- Vaccines may provide protection against specific diseases for months or years.



30 MINUTES CPD

Reading this excerpt gives you 30 minutes of CPD.

The complete tutorial offers five hours of CPD and covers basic microbiology, classification of microorganisms, disease transmission, body defences, prevention and control of infection, standard and additional (transmission-based) precautions, hospital acquired infections, multiple resistant microorganisms, quarantining, handling of sharps, needle stick injury and blood/body fluid exposure and real life infection control and prevention patient scenarios.

For further information you can contact the Federal Education Team at

education@anmf.org.au

RECOVERY – IS ONE PIECE OF THE PUZZLE MISSING?

By David Dwyer

The current biomedical model of addiction is a chronic, relapsing condition. As a result, we no longer talk of a cure, but rather a journey of recovery.

However, what is the nature of recovery? Humans are complex, and substance use affects all parts of their life and being. To treat the person, we must treat the person as a complex entity.

Aristotle claimed, "The whole is greater than the sum of its parts". If we ignore one part, one component of a person, are we ignoring the person?

The human being is a physical, psychological, psychosocial, social, emotional, intellectual and spiritual gestalt within a community construct. When we come to treat substance dependence and misuse, we address the following:

- physical withdrawal, with service guidelines and fact sheets;
- psychological, with liaison and/or referral to mental health services;
- psychosocial, with therapeutic communities, and working with families to varied levels of effectiveness; and
- social, with recommending employment, social networks and groups.

Yet what do we do about the spiritual element of someone's recovery?

We have policies and procedures to ensure cultural safety. We acknowledge the past and present custodians of the land. We have CALD (Culturally and Linguistically

Diverse) programs. We provide interpreters, ensure halal and kosher food, and support people in wearing cultural and religious apparel. But is this spirituality?

Are we comfortable, and how do we support a person who speaks of healing prayer and the power of their God?

William Miller (1998) said, "We routinely address and integrate the biological, psychosocial and social aspects of addiction and other mental health problems. Why not move towards models of health and treatment that include the spiritual side of humanity as well?"

Carroll et al. (2000) observed, "Despite this history and research findings, considerable guardedness, ignorance, bias and neglect can be observed among treatment staff regarding the value of examining/assessing and addressing the spiritual needs of clients, especially for those working in secular, government-funded treatment programs."

It has been my experience that most/many people taking substances are seeking to fill an empty space in their lives, to meet a spiritual need – often confirmed by the client themselves when the question is carefully and respectfully posited.

Ten years after Carroll et al. it appears we have made little progress in the matter. Doug Sellman (2010)



states, "Recovery from addiction involves the pursuit of higher ideals, a spiritual experience, which for some is best described as 'finding God'. Research into ways of assisting people more effectively and predictably re-orientate their lives is needed urgently to fill a gaping hole between current treatment methods and people's world-views and personal sense of purpose and meaning."

This can be confronting, as it challenges our understanding of our own personal spirituality.

Pierre Teilhard de Chardin is attributed as saying, "We are not human beings having a spiritual experience. We are spiritual beings having a human experience."

I ask, is spirituality our gaping hole in holistic care?

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ACT DRUG STRATEGY ACTION PLAN

A new Drug Strategy Action Plan on how to better prevent harms associated with alcohol, tobacco and other drugs is planned for the ACT.

The Action Plan 2018-2026 has been developed with input from a range of stakeholders, and summarises the ACT government's priority actions in relation to a range of issues.

"The Drug Strategy Action Plan has a clear focus on preventive health, with tobacco smoking and risky alcohol consumption being two of the key risk factors which contribute significantly to the burden of chronic disease in our community," said Minister for Health and Wellbeing Meegan Fitzharris.

"The Drug Strategy Action Plan is aligned to the National Drug Strategy 2017-2026 and aims to build safe, healthy and resilient communities through preventing

and minimising alcohol, tobacco and other drug-related health, social, cultural and economic harms among individuals, families and communities.

"In line with the national strategy, the ACT government will take a 'harm minimisation' approach, focussing on demand reduction, supply reduction and harm reduction.

"This threefold approach will look to prevent uptake and delay in first use, reduce harmful use and support people to recover; restrict availability and access to alcohol, tobacco and other drugs to prevent and reduce problems; and encourage safer behaviours and reduce preventable risk factors.

"Feedback to this consultation process will inform the ACT government's priority actions over the next three years in relation to the harmful effects of alcohol, tobacco and other drugs. I strongly encourage the community to take part in this consultation."

Further information on how to have your say and a copy of the Drug Strategy Action Plan is available at: yoursay.act.gov.au

MANDATORY TREATMENT FOR YOUNG PEOPLE WHO ARE DRUG DEPENDENT

The South Australian state government has introduced legislation to provide for the option of mandatory treatment for children and young people dependent on drugs.

The Controlled Substance (Youth Treatment Orders) Amendment Bill 2018 will enable parents who have been unable to engage their children in voluntary treatment to legally force their children to attend drug addiction programs in the hope of breaking addiction at the earliest possible time.

"Nobody understands the terrible impact of drug dependence better than a parent struggling to help a child experiencing drug problems," said State Minister for Health and Wellbeing Stephen Wade.

The legislation also recognises that the Youth Court, police officers, youth correction

officers and medical practitioners can have important insights into individual cases of young peoples' drug dependence and enables them to seek an order.

"What is critical is that we intervene in an effective manner to give the young person struggling with an addiction that best possible opportunity to break the addiction," said Minister Wade.

"This Bill offers parents and these other agencies an opportunity of last resort when it is clear that the young person has refused to engage in treatment and there is a significant risk to their health and wellbeing. They are putting themselves at significant risk and are in need of medical treatment."

The Youth Court would first make an assessment order to determine whether the young person is drug dependent, a danger to themselves or others and unlikely to voluntarily seek treatment.

Following an assessment order the Youth Court may make a treatment order requiring the young person to attend a treatment service.

The treatment provider will be required to report to both the young person undergoing treatment and the Youth Court.



"A broad consultation process will be undertaken with key health, justice and child protection agencies to ensure a model of care is developed that reflects the best available evidence," Minister Wade said.

"A review of the legislation will also take place three years after its commencement to determine its effectiveness and make recommendations for any amendments."



ALCOHOL USE DISORDERS IN WOMEN: A CLIENT GROUP WHO FALL THROUGH THE CRACKS

By Renee Brighton and Lorna Moxham

Alcohol use disorders (AUDs) significantly impact on the life of the person and those who provide care.

Unfortunately, however, people with AUDs, who often also have comorbidities, fall between the cracks as service provision increasingly becomes more specialised, criteria for engagement ever tighter and care becomes more compartmentalised.

The National Health and Medical Research Council suggests that 25% of Australians consume alcohol at risky levels.

Consumption above risky levels of two or more standard drinks per day is considered harmful and increases the lifetime risk of injury and disease.

Given that alcohol is an intrinsic part of the Australian culture, and with the increasing number of women drinking in harmful ways, there is an increased demand for services and an increased need to research reasons why.

Research into alcohol use from a quantitative perspective is well recognised but the views of people who live with AUDs is much more silent, with that of women, almost completely inaudible.

Women are particularly susceptible to alcohol related brain injuries placing them in a very vulnerable position, which according to the World Health Organization (2014, p8), 'is a major public health concern because alcohol use amongst women has been steadily increasing in line with economic development and changing gender roles'.

Women who consume harmful levels of alcohol are more likely to experience familial conflict and be victims of intimate partner violence and more than twice as likely to experience physical abuse. Women encounter more societal admonition and censure and experience considerably more guilt and shame about their alcohol consumption than men with AUDs.

Clear and consistent gender differences regarding the consequences of alcohol consumption appear in the literature but despite this evidence, only modest consideration has been afforded to women as a separate study population from men and there is an absolute lack of women centred services for AUD treatment.

As nurses, we can make sure we regularly screen women for AUDs even when they present with other issues. AUDs are not screened for as thoroughly as they could be with women at even higher risk than men of not being screened. This is despite medical evidence showing that they experience significantly more alcohol-related harm than men.

The care journey of women with AUDs is often unnecessarily convoluted because some health professionals feel that AUDs are 'self inflicted' and the individual does not 'deserve' treatment or therapy. The vast majority of nurses are caring and want to help people recover. Most importantly then, treat the woman with respect and dignity, be non-judgmental.

We do not know what is happening in their life now or what has happened. Being empathic and demonstrating unconditional positive regard may assist in help seeking behaviours and quite simply – it is integral to good nursing practice to deliver care that is free of judgement.



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AN UNDERGRADUATE NURSE'S EXPERIENCE OF PATIENTS WITH DRUG-SEEKING BEHAVIOURS

By Amelia Dawson, Stacy Blythe and Stephen McNally

There is a global rise in the misuse of both legal and illegal drugs that has been correlated with an increase in the number of Emergency Department (ED) presentations (Australian Institute of Health and Welfare, 2016).

Of concern, are reports that over one-third of ED presentations in New South Wales, Australia are related to the misuse of drugs and alcohol requiring some form of nursing intervention (Butler et al. 2016).

This subgroup of patients are difficult to manage due to the complexities of their needs and depend greatly on ED healthcare (Palepu et al. 2001; Tait et al. 2002; Krenske et al. 2004).

During an ED placement as an undergraduate nursing student, I experienced frequent encounters with patients requesting pain relief. There were several occasions when the registered nurse (RN) dismissed the patient's request for pain relief, justifying this with the rationale that the patient was drug-seeking and not in true pain. When trying to ascertain and learn how the RNs decision making had come to this conclusion, they struggled to provide rationale.

Upon further investigation, I noted there was an absence of comprehensive guidelines, protocols or policies related to the management of patients with drug-seeking behaviours

(DSB). This experience ignited my fascination of how nurses were able to determine DSB from true pain; as that scenario was also not discussed during my undergraduate studies.

To better understand how ED nurses identify and manage DSB, a review of the literature was undertaken. A paucity of papers investigating the emergency nurse's perspective of caring for this subgroup of patients was identified. A lack of clarity around DSB and Australian nursing practice guidelines, policies and protocols regarding the assessment, identification and management of patients with DSB was found (McCaffery et al. 2005).

Low report rates of patients with DSB was highlighted despite respondents acknowledging frequent encounters with this subgroup of patients (Kelleher & Cotter, 2009; Hamdan-Mansour et al. 2012).

Staff held negative attitudes and reported poor patient pain management (Hoskins et al. 2005; Hamdan-Mansour et al. 2012; Hsieh et al. 2013).

Different cultural perceptions and geographical contexts influenced how staff perceived DSB. If nurses did identify a patient as drug-seeking responses of ignoring the patient, administering the prescribed medication and informing the doctor were reported (Hamdan-Mansour et al. 2012).

Contemporary research particularly from an Australian perspective of nurses' experiences and knowledge of DSB is warranted.

Practical outcomes

This research has the ability to stimulate discourse and the development of policy and practice to educate RNs and enable the appropriate medical care for patients with DSB. There is an urgent need for specific education in relation to DSB. Such education will empower RNs to take effective actions to provide improved healthcare and pain management to persons with DSB. It may also help reduce the associated burden on ED nurses' time and the healthcare system's resources.

Amelia Dawson new graduate RN who has studied Bachelor of Advanced Nursing and is currently completing Research Honours

Dr Stephen McNally is Deputy Dean, Learning and Teaching and Chair: School Academic Committee and Dr Stacy Blythe is Senior Lecturer, Director Engagement.

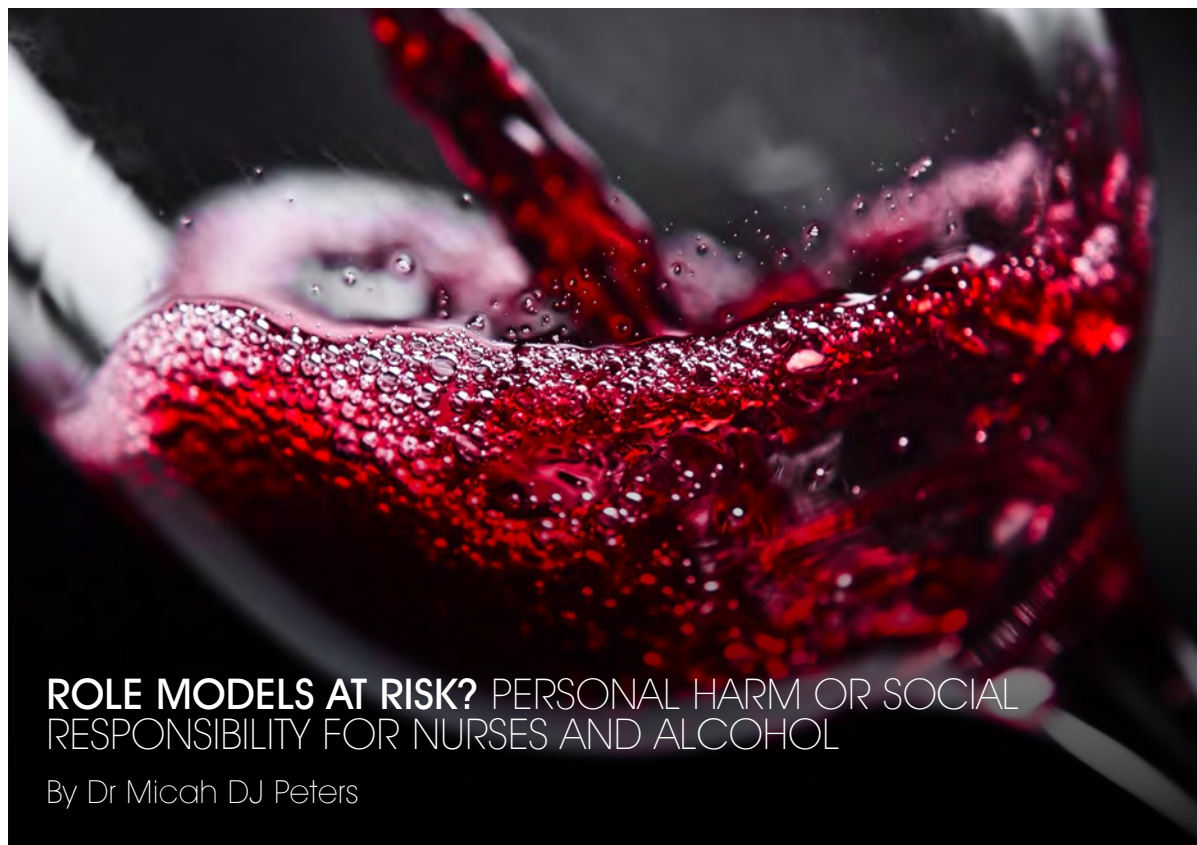
All are at Western Sydney University



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ROLE MODELS AT RISK? PERSONAL HARM OR SOCIAL RESPONSIBILITY FOR NURSES AND ALCOHOL

By Dr Micah DJ Peters

Nursing and midwifery work can be physically, mentally, and emotionally stressful (Dyrbye et al. 2017).

Like many people working in stressful roles, members of this workforce use many strategies to manage the pressures of their professions – both healthy, such as exercise and family activities, and potentially damaging, such as drinking, smoking, and displacement (Happell et al. 2012).

Recent research with ANMF/NSWNMA members in NSW has found that regardless of age and gender, nurses have higher levels of risky drinking than the general population (Perry et al. 2018). This is particularly worrying, as Australia is ranked on the higher end of the scale in relation to other countries by the World Health Organization for alcohol consumption per capita (WHO 2014).

Current Australian government recommendations suggest both men and women should ideally limit daily alcohol intake to no more than two standard drinks a day and no more than four standard drinks in one occasion (Australian government 2018). Drinking more than this may increase people's risks of long and short-term negative health and wellbeing effects.

It is concerning that a large and vital segment of Australia's health workforce may themselves be at greater risk of the potentially

damaging health impacts of drinking.

Beyond the possible personal harms that higher levels of drinking are associated with, what implications might this have for the role of nurses and midwives in public health?

Healthcare professionals including nurses and midwives are often regarded as important contributors to health promotion in the community.

However, little empirical evidence exists around how personal behaviours impact upon this activity.

A 2017 review found inconsistent and limited evidence regarding the relationship between the personal actions of nurses and their practice of health promotion activities (Kelly et al. 2017).

This review however, did not locate any studies addressing nurses' drinking behaviours. The review did find that nurses who engaged in unhealthy behaviours (eg. smoking, poor physical activity, diet, and weight) may be less positive in relation to health promotion and that conversely, those who felt that discussing health behaviours with consumers was important were more likely to do so.

It is also not clear whether consumers are more or less likely to trust or act upon health advice from nurses who do or do not practice healthy behaviours.

While we don't know the full picture regarding the impact of nurses' and midwives' personal choices regarding drinking upon

their capacity to convey health messages to the public, we do know the potential long and short-term risks and impacts associated with the consumption of alcohol.

We do know that the delivery of training and having a supportive working environment may actually influence nurse engagement with health promotion (Kelly et al. 2017). We also know that nurses and midwives face a great deal of stress and pressure in their work, as well as more sinister issues such as bullying and violence (Hartin et al. 2018), which can also be linked to alcohol consumption (Karata et al. 2016).

Together with the findings that nurses may engage in riskier drinking than the general Australian population, it is of great importance that nurses and midwives are supported to make healthy lifestyle decisions, which while personal, may be linked with professional capacity in health promotion.

Actions and interventions should focus on ways to support and protect nurses and midwives both within and beyond workplaces to be safe, healthy, happy, and productive as individuals and as community members.

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DRUG AND ALCOHOL NURSING INFORMATICS FOCUSED ON IMPROVING PATIENT CARE

By Jennifer Holmes

As a drug and alcohol nurse, I am fortunate to be able to bring together my clinical experience with my health informatics interest.

In 2013 I began working on a project to develop and implement an electronic medical record for community based Drug and Alcohol Services across NSW.

The Drug and Alcohol (D&A) Services based in 14 Local Health Districts across New South Wales have participated in the rollout of a standardised electronic medical record. The planning for this project began in 2013 and the final D&A service went live in November 2017.

Like it or loath it the Community Health Outpatient Care (CHOC) electronic Medical Record (eMR) is the most significant quality improvement activity undertaken by the public drug and alcohol sector in NSW in a decade.

Prior to the implementation of the CHOC eMR Drug and Alcohol services across NSW had no standardised clinical documentation or clinical processes. As part of the CHOC eMR planning process a statewide group of senior clinicians and information managers agreed upon a standardised set of core clinical processes and clinical

documents that then became the basis for the eMR development.

Despite there being no standardised clinical documents or clinical processes it became apparent through the project that Drug and Alcohol Services in NSW had more things in common than originally thought.

The agreed clinical processes became the basis of the workflow analysis and design of the CHOC eMR. The Drug and Alcohol core clinical processes are:

- intake (triage);
- comprehensive assessment;
- care planning;
- treatment monitoring; and
- discharge / transfer of care.

The implementation of the CHOC eMR involved significant change management challenges. The introduction of a computerised medical record into the therapeutic relationship with clients was a significant issue for many clinicians. D&A Services also introduced new clinical documents and adding clinical processes that had previously not been consistently undertaken. To address these challenges a clinical change management program was developed. Prior to the CHOC eMR implementation clinical process training was undertaken to introduce clinicians to the new clinical documents and clinical processes. Services that had active clinical champions within teams had the smoothest implementations.

An immediate benefit of the statewide rollout of CHOC eMR is that drug and alcohol clinicians who move between Local Health Districts use the same clinical information system. This significantly reduces orientation training.

The D&A CHOC eMR includes the Australian Treatment Outcome Profile (ATOP) (Ryan et al. 2014).

The ATOP is structured clinical interview divided into two domains frequency of substance use in the last 28 days and health and wellbeing questions. Clinicians complete the ATOP as part of the assessment process and it is repeated regularly (four, eight, 12 weekly) to assist with treatment monitoring and care planning.

Information from the ATOP can be easily graphed and shared with clients for immediate feedback on progress. An outcome metric using ATOP data is being developed for the main substances treated namely alcohol, opiates, cannabis and amphetamine type substances. The outcome metric will facilitate service level outcome reporting across services.

The introduction of the core clinical processes for the CHOC eMR has enabled the development of clinical care standards for drug and alcohol treatment services. A collaborative consultation process has been undertaken across the sector.

The development of the D&A Clinical Care Standards provides an opportunity for the introduction of computerised medical records auditing for quality indicator reporting and reducing the burden of the current manual medical records audit processes. Senior clinician and managers' time will be redirected from manual auditing processes to quality improvement activities.

It is very rewarding to have been part of the drug and alcohol sector's transition from paper based medical records to an electronic medical record that has such significant clinical safety and quality benefits.



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Jennifer Holmes is the Program Manager Data and Informatics at the Drug and Alcohol Services, South Eastern Sydney Local Health District.

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MIXED MESSAGES ABOUT DRINKING WHILE PREGNANT

By Susan Hickson

Midwives, how do you respond to pregnant women when they say "I have the occasional drink, just for special occasions, that's ok, isn't it?" Or "I drank during my other pregnancies and my kids are fine?"

Drinking alcohol during pregnancy increases the risk of miscarriage, still birth, low birth weight and birth defects - notably Fetal Alcohol Spectrum Disorder. Yet 25% of women in Australia continue to drink after their pregnancy is confirmed.

There are many reasons why a woman continues to drink when she is pregnant. Recent research (Hall and Partners Open Mind 2018) suggests that the National Health and Medical Research Council's (NHMRC) Guidelines to reduce the health risks from drinking alcohol (the Alcohol Guidelines) advice is not as effective as it could be in helping women abstain from alcohol while pregnant.

Alcohol Guideline 4 recommends that for women who are pregnant, planning pregnancy or breastfeeding, not drinking alcohol is 'the safest option' (NHMRC 2009).

Research commissioned in 2017 by the Foundation for Alcohol Research and Education (FARE) and supported

by the Australian Government Department of Health found that this guideline does not do enough to dispel the mixed messages that women receive about drinking occasionally or in small amounts while pregnant.

This was a key finding from review of the leaflet *Information for women about pregnancy and alcohol*, a component of FARE's Women Want to Know campaign that encourages health professionals to routinely discuss alcohol and pregnancy.

During focus group testing of the leaflet with women who were pregnant or planning pregnancy, advice based on the wording of Guideline 4 was seen as problematic, being viewed as friendly 'advice', not a firm recommendation.

This interpretation allowed some women to self-exclude from the message. The researchers noted that women who may be inclined to drink during their pregnancy found

justification in the existing statement that refers to an 'option'.

Recommendations to adopt a stronger approach to the message and the reasons behind it resulted in the new headline statement: 'If you are pregnant or planning pregnancy, experts advise no amount of alcohol is safe', and the unambiguous explanation 'This is because no amount of alcohol has been proven as safe'.

During testing, some women initially found the stronger messaging negative. However, there was consensus that given the possible consequences, this approach was necessary to help women abstain from alcohol, when they may not have if exposed to the original message.

A revised leaflet '*Information you might not know about pregnancy and alcohol*' was approved by the Department of Health and distributed throughout Australia in early 2018. The leaflet provides clear advice that will support the conversations midwives have with women about alcohol during the antenatal period. Additionally, the research that has informed the new resource will be used to advocate for review of NHMRC Alcohol Guideline 4.

Susan Hickson is a Health Promotion Officer at the Foundation for Alcohol Research and Education



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THE IMPORTANCE OF THE DEDICATED ALCOHOL AND OTHER DRUG NURSING ROLE

By Adam Searby and Darren Smyth

Problematic drug and alcohol (AOD) use results in increased healthcare expenditure, resource utilisation and repeat hospital admissions (Australian Institute of Health and Welfare, 2018).

Nurses, by the nature of their profession, are best placed to screen, assess, refer and initiate treatment for those with AOD use, however the specialist AOD nurse and nurse practitioner role is rare in contemporary Australian healthcare (Ling 2009).

A recent exploratory study conducted in a regional health service in New South Wales found that the presence of AOD nurses resulted in higher rates of screening and completion of assessment instruments in an electronic medical record (Smyth et al. 2018). This study

also found a correlation between awareness of the AOD nursing service and referrals, indicating that the presence of experienced AOD nurses may increase the confidence to refer individuals with problematic AOD use for specialist assessment and treatment.

Research indicates that nurses in many fields feel they lack the skills required to address problematic AOD use in healthcare settings (Searby et al. 2017).

Although a specialist field of nursing, AOD nurses and nurse practitioners provide an effective

modality to treat what is often considered a complex patient cohort. With the costs of providing healthcare to consumers with problematic AOD use shown to be high, the importance of AOD nursing roles should not be underestimated in providing cost effective and timely care and referral to appropriate treatment. In addition, the AOD nursing role has been shown to provide support and awareness of AOD use among diverse nursing fields, leading to increasing rates of screening and assessment.

Dr Adam Searby is a Lecturer at RMIT University and Education, Research and Workforce Development Officer of the Drug and Alcohol Nurses of Australasia (DANA)

Darren Smyth is a Nurse Practitioner and the President of the Drug and Alcohol Nurses of Australasia (DANA)



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CHISHOLM RESPONDS TO A GROWING DEMAND FOR MENTAL HEALTH WORKERS

Emily Flores, Marketing Manager, Chisholm Institute

Victorian vocational education and training provider Chisholm is launching the *Graduate Diploma in Alcohol and Other Drugs Addiction Counselling*, to address the growing demand for mental healthcare workers.

The post-graduate diploma has been developed in consultation with counsellors, psychologists, academics, policy makers, professional bodies and industry partners using the most up to date evidence base.

With up to one in three people suffering from mental illness, and the growing issues of substance abuse confounding these problems, Chisholm has developed a range of pathways from Cert III to post-graduate level.

Launched in July 2018, the degree is ideal for those in the health sector who wish to upgrade their skillset with an accredited post-graduate degree with emphasis on industry placement and counselling,

ensuring future healthcare workers meet industry requirements.

"We are very proud to be able to provide the fully accredited *Graduate Diploma in Alcohol and Other Drugs Addiction Counselling* to students and industry leaders," course coordinator Ben Allitt, PhD said.

"This degree is the culmination of industry partners and colleagues and is part of a unique pathway from Cert III to Graduate Diploma, enabling career success with the ability to support some of the most vulnerable people in society today."

Philip Cornish, General Manager, Health and Community Care, Chisholm Institute

said "We're thrilled to provide health and community care professionals with an opportunity to upskill and create better outcomes for those affected with mental health challenges."

In broadening their Community Services and Development offering, Chisholm continues to respond to the current and future needs of the health and community sector, by taking advantage of emerging research and prevention initiatives relating to mental health.

For upskilling professionals, the course can be completed part time over 12 months. A Degree qualification in a relevant discipline or a Diploma qualification in a relevant discipline plus at least two years in the family violence or related sector are required pre-requisites for the post-graduate course.

Chisholm Institute is a leader in vocational educational and training and offers over 300 courses across multiple locations in South-East Melbourne, Melbourne City, Bass Coast, Mornington Peninsula as well as via Chisholm Online and in the workplace. For more information visit chisholm.edu.au



ALCOHOL RELATED INJURY



By Christopher Clarke

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Professor Carol Grech

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The Australian Institute of Health and Welfare has identified injury prevention and control as one of the nine Australian National Health Priority areas due to the significant social and financial impact (AIHW 2015).

Injuries requiring hospitalisation in Australia most often occur as a result of traffic accidents, falls, interpersonal violence, sporting and recreational activities and from workplace accidents (AIHW 2015). In 2004-05, injury accounted for \$A3.4 billion allocated health expenditure in Australia – this was an increase of 22% since 2001 – the greatest proportion of which was spent during hospital admission (Curtis et al. 2012).

The use of alcohol is a risk factor for injury and elevated blood alcohol concentration (BAC) is present in up to 50% of patients that are injured (Afshar et al. 2014). Alcohol related injury in Australia cost more than \$15.3 billion in the period 2004-2005 (Browne et al. 2013) and continues to be a burden on the health budget.

Alcohol intoxication is a significant factor in patients presenting to hospital emergency departments (EDs) with a traumatic injury. Alcohol intoxication impairs cognitive, psychomotor and affective skills leading to compromised decision making, increased confidence and aggression. It can lead to increased risk-taking behaviour and appears to be a precipitant of trauma from causes including motor vehicle accidents, falls and interpersonal violence (Li et al. 1997; Watt et al. 2006). A study undertaken on the Gold Coast found that injured patients,

who consumed alcohol at levels above the National Health and Medical Research Council (NHMRC) risk guidelines, trebled their odds of sustaining a serious injury compared with minor injury (Watt et al. 2006).

Paramedics, doctors and nurses who work in the field of emergency medicine are at the forefront of caring for trauma patients with nurses being the primary caregivers 'at the bedside' during patients' Emergency Department (ED) admission.

However, in Australia, there has been very little research undertaken to inform best practice nursing care and clinical decision making in the management of trauma patients that have consumed alcohol.

A study is currently underway at the School of Nursing and Midwifery, University of South Australia, to ascertain the impact that the presence of alcohol has (or has not) on the management and care provided to patients with a traumatic head injury (THI) in the emergency setting. The findings of the study will inform clinical nursing practice guidelines and improve the safety and quality of care provided to this cohort of patients.

This mixed methods study will be divided into three phases, each with distinct aims and objectives. Mixed methods research is a methodology that involves collecting, analysing and integrating quantitative and qualitative research and data (Creswell 2003).

This form of inquiry provides a greater understanding and breadth of perspectives around a complex research problem than either research approach alone can provide. Mixed methods research involves multiple stages of data collection and allows for triangulating of data sources (Creswell 2003) for the purpose of generating practice relevant outcomes. Typically, for mixed

methods studies, research questions are posed rather than hypotheses generated as for quantitative experimental designs alone.

This study has three broad aims.

- To determine existing evidence in the literature surrounding the attitudes of staff that work in the area of emergency medicine towards patients that present under the influence of alcohol. This first aim is necessary in order to examine the extent and nature of current research and to clarify and refine what is currently known and use the findings to underpin subsequent phases of the study.
- To determine the association between clinician perception of patient alcohol use and clinician adherence to best practice head injury management guidelines.
- To describe the perceptions and attitudes of emergency clinicians (pre-hospital and emergency department) toward patients who present to the emergency department with an injury after alcohol consumption.

Alcohol consumption prior to injury has significant implications for the assessment and management of these patients and may interfere with the evaluation of brain damage severity (Lange et al. 2010). Alcohol is reported to be present in 35 to 50% of patients who present with a THI to the ED (Lange et al. 2010). Alcohol consumption does not result in clinically significant changes in the Glasgow Coma Score (GCS) for patients with blunt traumatic brain injury and it is recommended that patients with a THI should undergo prompt diagnostic and therapeutic investigations (Sperry et al. 2006).

However, some clinicians perceive that

alcohol consumption does contribute to an altered GCS and may delay diagnostic intervention and assessment until the patient is judged to be unaffected by alcohol (Struck et al. 2009). This practice may lead to increased morbidity and mortality (Struck et al. 2009).

Internationally, few studies have examined the attitudes and beliefs of ED staff in relation to alcohol related presentations (Huntley, Patton & Touquet 2004; Indig et al. 2009; Warren et al. 2012). Of these, most have investigated alcohol presentations associated in general. From these studies it appears that many clinicians hold negative attitudes toward patients who present to the ED after alcohol use.

It has been shown that increased years of clinical experience is associated with negative perception of alcohol related patient presentations (Huntley, Patton & Touquet 2004). In a study by Warren and colleagues (2012), emergency care providers reported that patients who had consumed alcohol should be treated with the same level of care and respect as for any other person presenting to ED, but felt that this did not occur in clinical practice (Warren et al. 2012).

Another study that examined intoxicated trauma patients was undertaken in South Africa (Kabale et al. 2013).

This study concluded that healthcare professionals experience negative emotions and develop negative attitudes in response

to alcohol-intoxicated patients who have been assaulted.

Key themes identified from this research centred on perceived waste of resources, individual safety and communication issues.

In Australia, previous research has identified barriers in providing treatment to patients who are alcohol intoxicated in the ED.

These barriers included: time difficulties, insufficient resources, and lack of knowledge in assisting with alcohol related problems (Indig et al. 2009).

There is a paucity of research that has examined staff perceptions of alcohol related presentations to the ED in Australia and none that have specifically investigated staff perceptions to patients who present with a THI after consuming alcohol and if the presence of alcohol is a factor in suboptimal care.



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www.climate.edu.au

AUGUST

Lung Health Promotion Centre at The Alfred Asthma Educator's Course
1-3 August
COPD – From Diagnosis to Management
9-10 August
Spirometry Principles & Practice
13-14 August
A Practical Management Approach of Non Invasive Ventilation & Sleep Disorders
16-17 August
Sleep: the how, why & the what – skills for your toolkit
16 August
The Pressure to Breathe – the skills for success with NIV
17 August
Respiratory Course (Modules A & B)
20-23 August
Respiratory Course (Module A)
20-21 August
Respiratory Course (Module B)
22-23 August
Ph: (03) 9076 2382
Email: lunghealth@alfred.org.au

National Aboriginal & Torres Strait Islander Children's Day
4 August

A5M Anti-Ageing and Aesthetics Conference
Connecting inner and outer health
4-5 August, Sofitel Hotel Melbourne.
a5m.net/conference-information/
a5m-annual-conference

19th International Mental Health Conference
Our treatment. Our environment.
Our strategies
8-10 August, RACV Royal Pines,
Gold Coast. anzmh.asn.au/conference/

International Day of the World's Indigenous Peoples
9 August

17th International Congress of Circumpolar Health
12-15 August, Copenhagen,
Denmark. icch2018.com/

Hyperbaric Technicians and Nurses Association and Australia New Zealand Hyperbaric Medicine Group 26th Annual Scientific Meeting
16-18 August, The Bandha Hotel and Suites, Legian, Bali, Indonesia.
htna.com.au/index.php

Vietnam Veterans' Day
18 August

Australian College of Nursing CPD Face to Face: Wound Management Update
20 August, Dubbo. This face-to-face course is conducted over two days and is equivalent to 14 (CPD) hours. The course is designed for registered and enrolled nurses from all health sectors, who are engaged in providing wound care to patients or residents. This is an in-depth review of pathophysiology, pharmacology, assessment strategies, clinical aetiologies and interventions. acn.edu.au/wound-management-update-2018

19th Asia-Pacific Prostate Cancer Conference 2018
22-25 August, Brisbane Convention and Exhibition Centre. The program will involve locally advanced and metastatic prostate cancer, research, diagnosis and management with nursing and allied health specific sessions over the three days. prostatecancerconference.org.au

10th ICN Nurse Practitioners/Advanced Practice Nurses Conference
Bridging the gap
26-29 August, Rotterdam,
The Netherlands. npapn2018.com/

Lynch Syndrome Australia national symposium
Taking Control: Surviving and Thriving
30 August, Garvan Institute of Medical Research, Sydney Further information on the symposium including registration details can be found at lynchsyndrome.org.au/taking-control-surviving-and-thriving-symposium/

SEPTEMBER

Indigenous Literacy Day
5 September

Australian College of Nursing CPD Face to Face: Wound Management Update
10 September, Hobart. This face-to-face course is conducted over two days and is equivalent to 14 (CPD) hours. The course is designed for registered and enrolled nurses from all health sectors, who are engaged in providing wound care to patients or residents. This is an in-depth review of pathophysiology, pharmacology, assessment strategies, clinical aetiologies and interventions. acn.edu.au/wound-management-update-2018

Australian College of Nurse Practitioners National Conference Dimensions in Care
10-13 September, The Hellenic Club
Canberra. acnpconference.com.au/

Anniversary of the UN Declaration on the Rights of Indigenous People
13 September

Congress of Aboriginal & Torres Strait Islander Nurses & Midwives (CATSiNaM) National Professional Development Conference
Honouring our past, empowering our present, growing our future
17-19 September, Hilton Adelaide,
SA. catsinam.org.au/

International Rural & Remote Nursing & Midwifery Conference in conjunction with CRANAplus 36th Annual Conference
Leading primary healthcare in a challenging world
20-22 September, Pullman
Cairns International Hotel, Qld.
cranconference.com/

Exploring Innovations and Latest Advancements in Pediatric Nursing and Healthcare
21-22 September, Vancouver, Canada.
pediatricnursing.nursingconference.com/

Australian Public Health Conference
26-28 September, Pullman Cairns
International Hotel, Qld.
phaa.net.au/events/event/australian-public-health-conference-2018

OCTOBER

51st World Nursing Leadership & Management Conference
Exploring the leadership practices in nursing and management
4-5 October, Moscow,
Russia. nursingleadership.
nursingmeetings.com/

Lactation Consultants of Australia and New Zealand Breastfeeding Conference
5-6 October, Stamford Grand
Adelaide, Glenelg, South Australia.
lcanzconference.com or lcanz2018@
theassociationsofspecialists.com.au

33rd Euro Nursing & Medicare Summit
Accelerating Innovations & Fostering
Advances in Nursing and Healthcare
8-10 October, Edinburgh, Scotland.
europe.nursingconference.com/

42nd International Hospital Federation World Hospital Congress
10-12 October, Brisbane Convention
& Exhibition Centre, Qld.
event.icebergevents.com.au/whc2018

19th South Pacific Nurses Forum hosted by Cook Islands Nurses Association Aotearoa
Transforming leadership – Nurses as change agents for non communicable diseases in the Pacific
15-19 October, Rarortonga, Cook
Islands. spnf.org.au/2018/19th_
SPNF_Registration_Form.pdf

21st Australian College of Midwives National Conference
Coming of age
15-18 October, Crowne Plaza Perth.
midwives.org.au/

Lung Health Promotion Centre at The Alfred Asthma Educator's Course
31 October-2 November
Ph: (03) 9076 2382
Email: lunghealth@alfred.org.au

NOVEMBER

Australian College of Nursing CPD Face to Face: Wound Management Update
1 November, Canberra. This face-to-face course is conducted over two days and is equivalent to 14 (CPD) hours. The course is designed for registered and enrolled nurses from all health sectors, who are engaged in providing wound care to patients or residents. This is an in-depth review of pathophysiology, pharmacology, assessment strategies, clinical aetiologies and interventions. acn.edu.au/wound-management-update-2018

Melbourne Cup Day
6 November

Australian College of Nursing CPD Face to Face: Wound Management Update
8 November, Darwin. This face-to-face course is conducted over two days and is equivalent to 14 (CPD) hours. The course is designed for registered and enrolled nurses from all health sectors, who are engaged in providing wound care to patients or residents. This is an in-depth review of pathophysiology, pharmacology, assessment strategies, clinical aetiologies and interventions. acn.edu.au/wound-management-update-2018

Remembrance Day
11 November

22nd International Conference on Global Nursing Education & Research
Innovation & advancements in nursing education and research
12-13 November, Melbourne,
Australia. nursingeducation.
conferenceseries.com/

Lung Health Promotion Centre at The Alfred Smoking Cessation Facilitator's Course
15-16 November
Spirometry Principles & Practice
22-23 November
Ph: (03) 9076 2382
Email: lunghealth@alfred.org.au

NETWORK

Queen Elizabeth Hospital, SA, Group 9/88 30-year reunion
15 August (drinks) and 22 September (reunion dinner). Contact Rosie Ratcliff (nee Barber)
E: larmratcliff@bigpond.com

St Vincent's Graduate Nurses Anniversary Lunch
30 August, 11.30 to 3.00pm, Park Hyatt Melbourne.
E: stvzna@gmail.com

Alfred Hospital Group 3/85, 30-year reunion
20 October.
E: cathie@coughlan.id.au or
boxvale2@bigpond.com or
perilloj@gmail.com

Royal Adelaide Hospital, Group 791, 40-year reunion
January 2019. Past Students register your interest to Margie Hayes (nee Kennedy) E: mdhayes@adam.com.au; Merridee Seiboth E: merridee.seiboth@health.sa.gov.au; Julie Schiller (nee Luders)
E: julie.schiller@health.sa.gov.au

Royal Adelaide Hospital, Groups 793/4, 40-year reunion
May 2019. Past students register interest with Julie Hoyle (nee Lloyd)
E: djhoyle@bigpond.net.au or
Andrew Booth
E: andrew.booth@sa.gov.au

Western General Hospital 60th PTS reunion
16-23 June 2019, Port Vila, Vanuatu.
Contact Wendy
E: Wendyflahive@gmail.com

EMAIL cathy@anmf.org.au if you would like to place a reunion notice

UNSATISFACTORY AND UNRESPONSIVE DESIGN

In a very interesting article, "An unsatisfactory finding" (ANMJ, 2018, v25 n10 p32) about a recent Coronial Inquiry, Associate Professor Linda Starr warns of the dangers of allowing others to enter their notes using your Electronic Health Record (EHR) login, and of relying on a verbal handover.

She writes the Coroner found in relation to the EHR that "... not only technological issues need addressing but also poor adherence to policy". The practice of allowing others to use your login to enter notes is prohibited under the rules and policies that regulate the use of the EHR.

These findings are unsatisfactory in that they do not address why such policy may not be adhered to in the first place.

We now live in the age of "design". In the past workplace systems—such as handovers and record-keeping—were derived from practices in specific workplaces. In essence it was trial and error. Seeing what was done, tweaking it, and trying again. The basis of science.

What we are working with now are imposed non-negotiable systems that direct or prohibit us. They are designed from the outset to achieve specific goals. The problem is that the goals they desire and the work patterns they require often make it harder for users. They also generally don't encourage feedback mechanisms or workplace modifications.

In the case cited, the nurse said it was common practice to stay logged into the EHR so others could use it.

It means the EHR system was not responsive to the demands of working on the floor. Because of that, nurses were relying on verbal handovers.

I venture nurses would have complained to their managers about EHR workplace demands. What happened to those complaints?

Forcing reliance on an unworkable EHR system is a recipe for disaster. A verbal handover is not inherently dangerous: the key is the accuracy and clarity of the information.

Writing verbal handover information onto a running sheet and transferring that to the EHR when workload permits would result in better care, and a more accurate EHR.

EHR designers and their clients need to look beyond the interface, into the real world where nurses are generally under immense pressure from numerous and often conflicting sources, and take lessons from what they see.

Dr Niko Leka EN, NSW



LETTER
OF THE
MONTH

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MANAGING DIABETICS

Reading the reflection on Open disclosure, ANMJ, June 2018, I'm yet again staggered by one sentence. "Did you fail to administer insulin resulting in elevated blood glucose levels?"

Surely this should read "Did you serve a known diabetic two slices of bread, a box of cereal, fruit juice, fruit in a box, and skim milk and expect that they wouldn't have elevated blood glucose levels?"

It's time nurses, doctors, dieticians and hospitals relearn all they think they know about BSL and dietary impact. As a student nurse in the 80s we served breakfast of bacon, eggs, and porridge and only the elderly had Type 2 DM.

While a nurse in England has just won an award for promoting a better way of eating for diabetics with amazing results, AHPRA has 'silenced' an orthopaedic surgeon from giving dietary advice (he was reversing T2DM and not amputating so many limbs), but seriously? How long are we going to persist with this Earth is flat nonsense.

Jeanine McKenna RN, VIC

NEW WEBSITE A WINNER

I am loving your new website, ANMJ.

I am finding a great array of informative articles on a variety of topics. I am sure there is something for everyone on this site.

For me, the wellbeing stories are helpful to my day-to-day practice, while the news stories keep me updated with what's happening in my industry, easily and quickly.

Keep up the good work. I look forward to more great articles from you.

Julie Marks RN, VIC
(Editor's note: To view the website go to anmj.org.au)

MEDICALLY SUPERVISED INJECTING CENTRE IN MELBOURNE WILL SAVE LIVES

Lori-Anne Sharp, Assistant Federal Secretary

Last month, Melbourne opened its first medically supervised injecting centre (MSIC). Its location in North Richmond is one I know well, having worked there as a community health outreach nurse in 2008–2009.

While providing healthcare to people experiencing homelessness in Richmond and its surrounds, I witnessed daily the tragic impact of drug overdoses on not just drug users themselves, but also their families, friends and wider community.

During 2017, there were 34 overdose deaths in Victoria Street Richmond alone. Then there are people who are resuscitated but end up with acquired brain injuries that will require long term care.

We should also consider the impact on emergency services and hospitals. I respect and admire the role community nurses and emergency workers play on the front line. Like the majority of them, I welcome the opening of the MSIC and look forward to a decrease in avoidable fatalities.

Since the world's first MSIC opened in Bern, Switzerland in 1986, the number of centres has grown. There are now 100 known MSICs in 63 cities across 10 countries.

MSICs are specialised facilities where individuals who use illicit drugs can self-administer with medical assistance or under supervision without fear of legal retribution. The benefits of reducing fatal and non-fatal overdoses and the spread of blood-borne infections such as Hepatitis C and HIV are widely recognised.

On a public health and safety front, the general community also benefits from reduced contaminated drug litter on the streets and not having to experience the trauma of discovering a person dying from a drug overdose.

Sydney's King Cross MSIC (on which the Melbourne centre has been modelled) opened in 2001. In the seventeen years since, it has supervised one million injectors and managed more than 7,500 overdoses without a single death. Its workers have made more than 12,500 referrals to a range of health and welfare services, including for drug addiction treatment. In this time there has been an 80% reduction in ambulance call-

outs, freeing up emergency services to attend to other work.

In 2006 a survey of local residents found that 75% had noticed a decrease in discarded needles and 90% believed the facility to be of benefit to their community (Salmon et al.)

Nurses play a crucial role in MSICs. They offer education on safety, hygiene and harm minimisation strategies, and access to clean needles, sharps disposal, medical assistance, supervision, and drug rehabilitation programs. Offering a non-judgemental environment where people can feel safe, MSICs can make the world of difference.

Many MSIC clients may be experiencing homelessness and significant physical and/or mental health issues, and to people seeking help, the MSIC will be a vital link to counselling, detox and homelessness services.

MSIC allow for crucial opportunities for dialogue with some of the most vulnerable.



Reference

Salmon A.M., Thein H.G., Kimber J., Kaldor M. and Maher L. 2007 Five years on: What are the community perceptions of drug related public amenity following the establishment of the Sydney Medically Supervised Injecting Centre? *The International Journal of Drug Policy*, 2007

Let's not forget too that people accessing an MSIC are often some of the most ignored and disadvantaged in our society. A kind and gentle conversation with a nurse might be the only real conversation they have that day.

Nurses understand the importance of valuing and dignifying the lives of all. Nurses also understand the vital role harm minimisation plays in addressing street-based injecting drug use, overdose, mortality and morbidity.

We can play an important role in educating the community on the value of MSICs.

It is important to understand that supporting the MSIC does not equate to encouraging the use of illicit drugs. Arresting drug users does nothing to help them stop using or make our streets safer. Education, proactive non-judgemental support and the use of harm minimisation strategies do work, and that is why this trial should be supported.



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